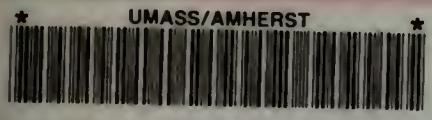


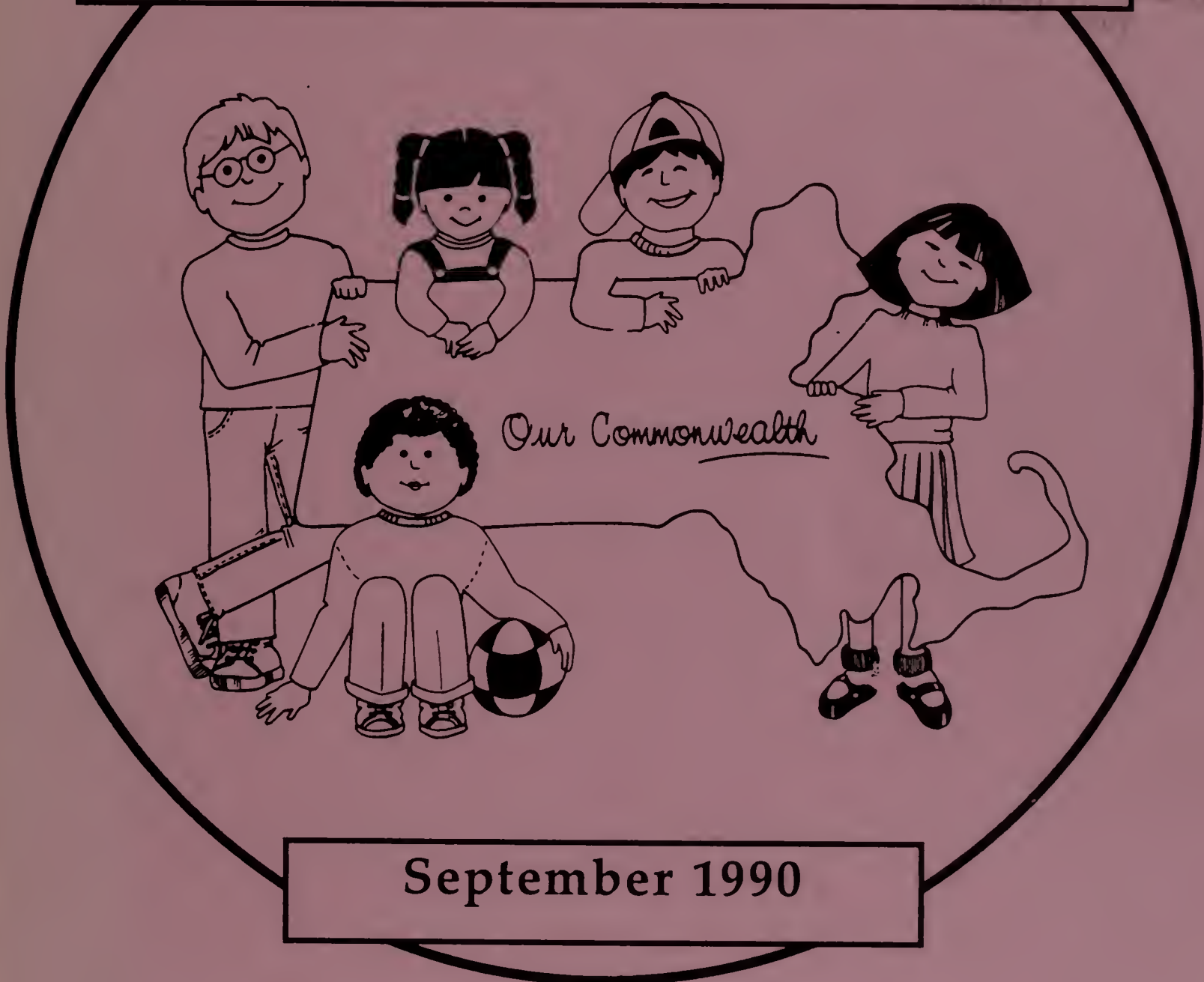
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CHILD WELFARE SERVICES PLAN

Title IV-B Plan
For F.F.Y. 1991



September 1990

Commonwealth of Massachusetts
Michael S. Dukakis, Governor
Philip W. Johnston, Secretary
Executive Office of Human Services

Marie A. Matava, Commissioner
Department of Social Services
150 Causeway Street, Boston, MA 02114

904/112



Marie A. Matava
Commissioner

The Commonwealth of Massachusetts

Executive Office of Human Services

Department of Social Services

150 Causeway Street

Boston, MA 02114

Tel: (617) 727-0900

September 3, 1990

Dr. A. Kenton Williams
Regional Administrator, Region I
John F. Kennedy Federal Building
Government Center
Boston, MA 02203

Dear Dr. Williams: *Kenton*

Attached you will find a copy of the final draft of the Department of Social Services (DSS) FFY'91 IV-B Child Welfare Services Plan. The Plan is the result of joint planning between the Administration for Children, Youth and Families (ACYF) and DSS staff which began in June.

The Plan is also being submitted through the Commonwealth of Massachusetts approval process.

Please extend my sincere thanks to those members of your staff who participated in the development and review of the plan. A special thanks should go to John Tretton for his input and assistance.

I look forward to receiving approval of the plan, and continuing our joint efforts to provide coordinated Child Welfare Services to citizens of Massachusetts. If you have any questions, please contact William S. Dolan, Director of External Relations, at 727-0900, extension 259.

Sincerely,

Marie A. Matava
Marie A. Matava
Commissioner

MAM:am

cc: John Tretton, Children's Services Specialist



THE COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE DEPARTMENT

STATE HOUSE • BOSTON 02133

MICHAEL S. DUKAKIS
GOVERNOR

September 4, 1990

Mr. Richard Stirling
Regional Program Director
Administration for Children, Youth
and Families
John F. Kennedy Building
Boston, MA 02203

Dear Mr. Stirling:

I am pleased to submit to you my approval of the FFY'91 State Plan for the Commonwealth of Massachusetts under Title IV-B of the Social Security Act. In addition, I certify that the Department of Social Services is the agency designated to submit and administer the Plan.

Sincerely,

Michael S. Dukakis
Governor

MSD:MAM:aw

cc: Secretary Philip W. Johnston, EOHS
Commissioner Marie A. Matava, DSS

FFY'91

IV-B PLAN

CHAPTER I

INTRODUCTION

I. INTRODUCTION

The Department of Social Services (DSS) is pleased to present its Child Welfare Services Plan for FFY'91 -'93. This plan sets forth the major initiatives that the Department will undertake in the next three years in order to carry out its mission as the state agency responsible for providing social services to children and families of the Commonwealth. The plan also addresses the requirements called for by Title IV-B of the Social Security Act, under which Federal funds are provided to the states for strengthening and improving child welfare services.

Services to children and their families are the predominant focus of the Department of Social Services. The Department of Social Services is the agency designated by Governor Dukakis to submit and administer the Child Welfare Services Plan and Program as required by Title IV-B of the Social Security Act. The legislation which created the Department mandates that DSS provide and administer a comprehensive area based program of social services. Specifically, Chapter 18B, Section 3 articulates the purposes and philosophical foundations of the Department:

"The Department shall establish a comprehensive program of social services at the area level and, to promote such program, shall divide the Commonwealth into regions and areas consistent with those established by the Secretary of Human Services..."

I. INTRODUCTION

In order that the area-based social services be adapted, organized and coordinated to meet the needs of certain population groups, the Department provides programs of service for:

- (1) families, children and unmarried parents, which program shall, among other objectives, serve to assist, strengthen and encourage family life for the protection and care of children, assist and encourage the use by any family of all available resources to this end, and provide substitute care of children only when preventive services have failed and the family itself, or the resources needed and provided to the family, are unable to insure the integrity of the family and the necessary care and protection to guarantee the rights of any child to sound health and normal physical, mental, spiritual and moral development.
- (2) other population groups which require special adaptation of the services provided because of special needs.

FY'90 DEPARTMENT OF SOCIAL SERVICES REORGANIZATION

As a result of the fiscal constraints confronting the Commonwealth, during FY'90 DSS reorganized its central, regional and area office organizational structure. The cumulative impact of the FY'90 budget process resulted in the reduction of 100 personnel positions and a further reduction of \$16M in the Department's FY'90 operational budget.

The FY'90 reductions, coupled with FY'89 cuts of 120 administrative personnel positions, forced the Department to develop a significantly scaled down organizational structure.

I. INTRODUCTION

Despite the elimination of 220 administrative and support positions in the past two years and rising social worker caseloads, as a result of increased reports of child abuse and neglect, the Department is committed to maintaining the level and quality of services it provides to the Commonwealth's children and families.

During FY'90 the Department reduced its six existing regional offices to four small field support offices and consolidated its 40 areas into 26 areas. The new territories and their present family caseload size are as follows:

- o Western Region (Berkshire, Franklin, Hampshire, Hampden and Worcester Counties), Caseload size: 5,800 families
- o Northeast Region (Middlesex and Essex Counties), Caseload size: 5,800 families
- o Southeast Region (Norfolk, Bristol, Plymouth, Barnstable, Dukes and Nantucket Counties), Caseload size: 5,200
- o Boston/Brookline Region (Suffolk County and the town of Brookline), Caseload size: 5,800 families

The Department's reorganization was not designed to eliminate or reduce, in any way, the level or availability of client services at the area office level. The restructuring of the Department's regional and area office system was designed along existing county boundaries to ensure the continuation of efficient client service delivery throughout the Commonwealth. With the elimination of two regional offices it was necessary to consolidate

I. INTRODUCTION

area offices withing the new geographic territories to ensure continued administrative support of the areas.

Consolidation of areas did reduce the Department's capacity to provide services but allowed for a more efficient and manageable structure with the reorganized system. In those regions where two or more area offices have been consolidated and there remain at least two physical sites, the area offices is headed by an Area Director and the secondary site is managed by a Director of the Social Service Center.

Even though it faced serious fiscal constraints during FY'90, the Department continued to face the challenge of providing quality child welfare services to the children and families of the Commonwealth. The following pages contain a summary of the casework issues and fiscal realities confronting the Department. The state FY'91 Agency budget is currently under analysis. This analysis will be shared with DHHS staff upon its completion.

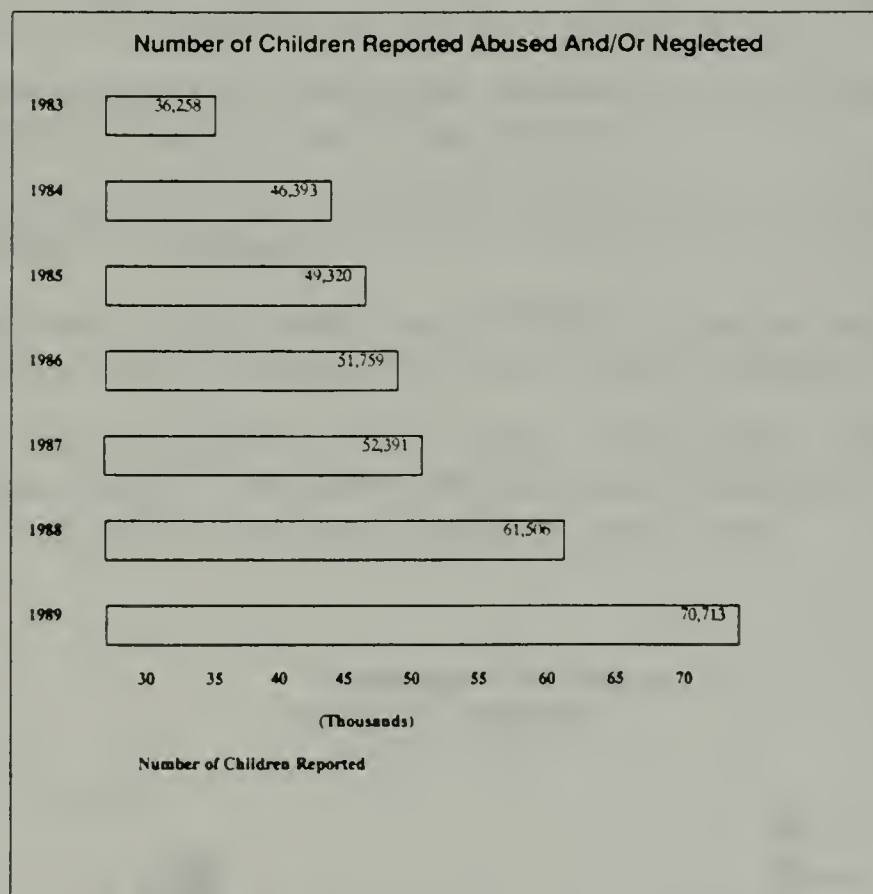
Department of Social Services

Children At Risk - Effects of Substance Abuse on Family Violence

The Department of Social Services has been greatly impacted by increased drug and alcohol use among families. Often misperceived as an individual problem, substance abuse is now taking its toll on families and children. The effects are seen in dramatic rises in the number of children reported abused and neglected, children neglected because of parental drug abuse, children with AIDS, children (in particular under five) in foster care and infant deaths over the last few years. Below are more detailed breakdowns of the numbers and results of research studies looking at this trend.

Child Abuse and Neglect

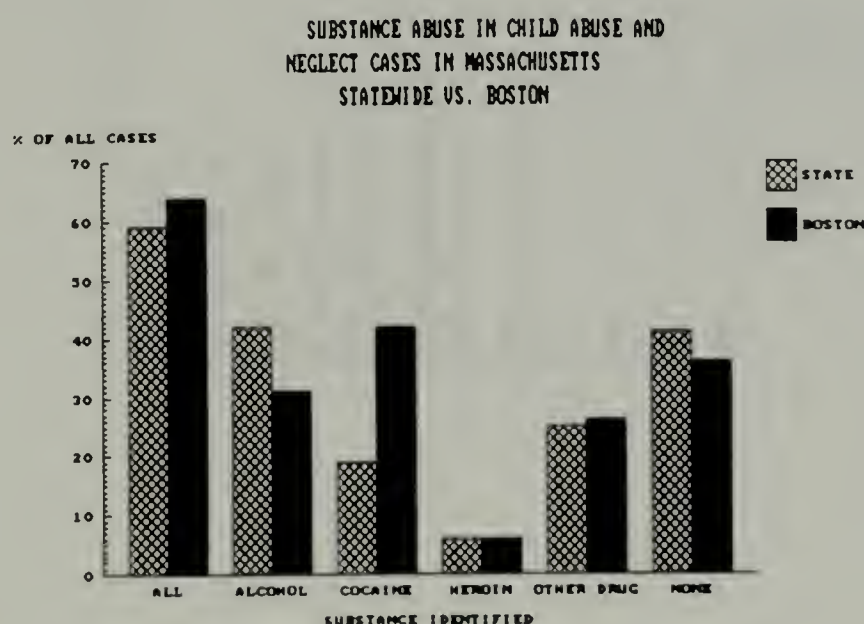
- In 1989, there were 70,713 children reported abused and neglected. This is a 15% increase over 1988.
- There were 15,000 children reported abused or neglect in 1980, the year the agency began.
- In 1989, there were 22,532 children with supported investigations, a 19% increase over 1988.
- Intakes due to supported investigations increased by 33% comparing the first quarter of FY '89 to the first quarter of FY '90, meaning we are seeing more families for the first time.



	Consumers	Families	Children (under 18)
6/86	74,769	25,035	40,511
6/87	66,016	21,208	37,397
6/88	67,658	21,821	38,792
6/89	70,052	22,442	40,497
12/89	72,806	23,181	42,284

Substance Abuse

- In 1989 there were 353 children with supported investigations for congenital drug addiction to opiate drugs. This number has more than quadrupled since 1984 when there were 82. There is a strong feeling that reports of drugs other than opiates are significantly underreported because few hospitals do this type of testing. It is felt that the majority of the reports of cocaine, amphetamines, etc. come from Boston.
- A recent DSS study revealed substance abuse as a concurrent factor in 64% of all supported investigations of physical abuse, neglect and emotional maltreatment in Boston. State wide the percentage was 59%.
- In the Boston study, almost all of the supported reports of child abuse or neglect involving children under one (34 of 38 or 89%) were in families where one or more members were identified as substance abusers during the investigations and 23 of the 34 (68%) were hospital reports of newborns with congenital drug addiction (6), positive toxic screens for cocaine (20), or fetal alcohol syndrome (4).
- DSS has found it increasingly necessary to divert Family Support Services (FSS) monies to pay for random drug testing of DSS consumers. These monies were historically used for purposes such as camperships for children in need, home-based services, etc. In the latter part of FY '89, one DSS area office estimates \$500 out of a total of \$650 spent in FSS funds was used for drug testing.
- Estimates are that 5000 drug affected babies are born yearly in Mass.
- The increasing prevalence of AIDS in DSS children is directly attributable to intravenous drug usage by the mother or her partner.
- It is projected that DSS/DPW will spend \$2.8 million in FY '91 for care of 113 known/projected HIV + children.
- Based on a recent case, it costs more than \$80,000 in medical expenses to maintain a child with AIDS in a foster home during the last year of the child's life.
- Because children increasingly can not be made safe in their homes more care and protection petitions (M.G.L. ch. 119 s 24-30) must be filed and more children are being removed from their homes and placed in foster care.

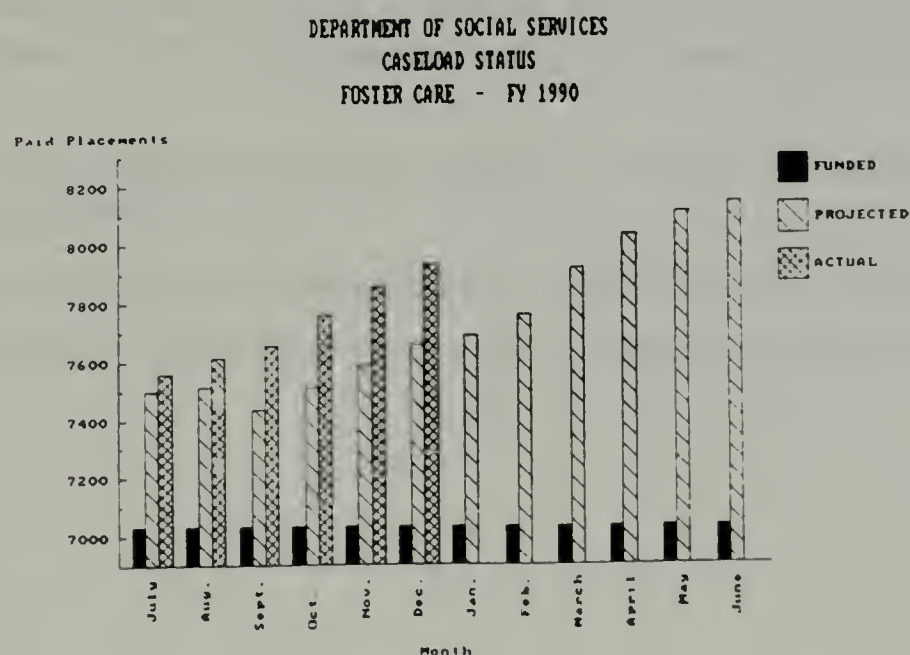


Foster Care

- In December of 1989, there were 8455 children in foster care (a 20% increase over the last 18 months. There was an additional 1,552 children in community residences.
- It is projected that the number of children in foster care will be over 8500 by June, 1990.
- There has been a 73% increase from June, 1987 to June, 1989 in children under two years of age in care. In Boston there has been a 109% increase to 311.
- Placements with relatives for children under two years of age increased 68% from September of 1988 to September, 1989.
- It is generally agreed that these increases are due to the escalating use of cocaine and other drugs and their effects on the ability of families to care for children.

Age Distribution of Children in Foster Care 1986 - 1989					
	0 - 2	> 2 - 5	> 5 - 12	> 12 +	Total
6/86	503	987	1961	3210	6661
6/87	517 +3%	1066 +8%	2078 +6%	3052 -5%	6713
6/88	688 +33%	1229 +15%	2292 +10%	2851 -7%	7060
6/89	893 +30%	1447 +18%	2727 +19%	2810 -1%	7877
12/89	n/a	n/a	n/a	n/a	8455

- The rapid increase in out-of-home placements has far outstripped our available dollars. Currently DSS/EOHS/EOAF project a \$8.2m deficiency in this account.



Child Deaths

- There was a 22% increase in all child deaths known to DSS from 1988 to 1989. (68 in 1988, 83 in 1989) The increase was entirely attributable to the increase in infant deaths. (24 in 1988, 43 in 1989)
- Of the 43 infant deaths in 1989 (58% higher than 1988), 22 were definitely preceded by drug and/or alcohol use during pregnancy and at least four others were possibly preceded by substance abuse.
- Seventeen of the 22 involved cocaine.
- Average age at the time of death was 84 days.
- Causes of death, in the majority of cases, were SIDS and SIDS-like diagnoses, such as cardiac or respiratory arrest. Cocaine linked deaths also were characterized as due to extreme prematurity or placenta abruption.
- The average age of the mothers was 26 years.
- In December, 1989 eight children died. Below is a synopsis.

Boston - 21 day old, second of twins born at 24 weeks gestation with positive toxic screen (alcohol and cocaine). First twin died prior to the filing of 51A. Death due to prematurity. Family not known to DSS.

Cambridge - Six week old died from complications from a drug addicted birth. Case not opened to DSS at time of birth. Five other children all in custody and living with maternal grandmother. Mother was released from MCI-Framingham in June after serving time for heroin and cocaine use.

Framingham - 21 day old, medically involved child, premature birth. Mother enrolled in a drug program. DSS involved as a result of other children who are in custody of maternal grandmother.

Lawrence - Born at 21 weeks gestation, baby lived on its own for one hour. Mother admitted to using IV drugs. It is an open protective case with two other siblings for neglect.

Boston - One month old, family living at Milner Hotel. Mother put baby to sleep and found her dead two hours later. DSS involved less than a year after supported allegation of medical neglect.

North Andover - Four month old died of SIDS. Case was opened in 1988 for neglect on a sibling. No 51A's since 1988.

Worcester - 14 year old died of asthma attack. CHINS case committed to DSS.

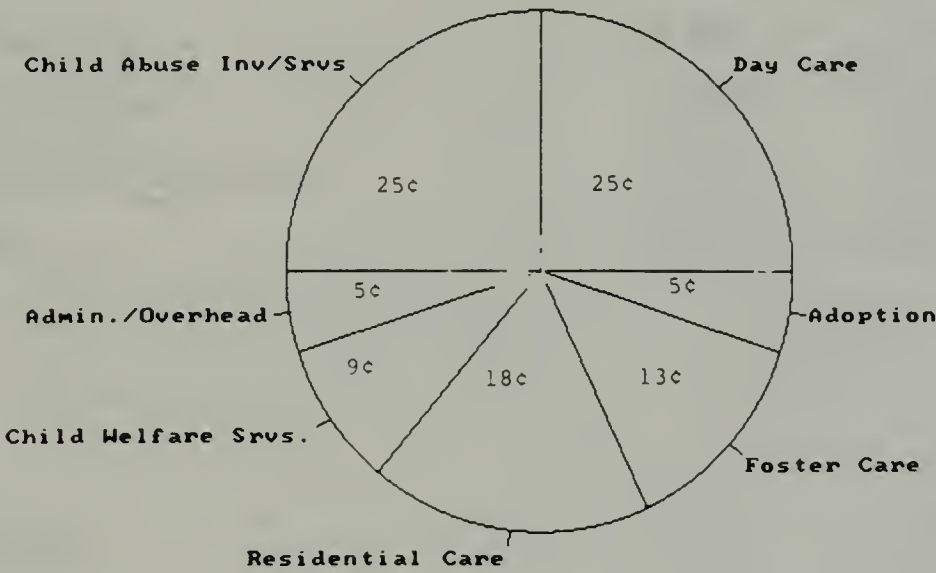
Pembroke - Five year old child died from upper respiratory infection. Child was multiply handicapped.

DSS Resources

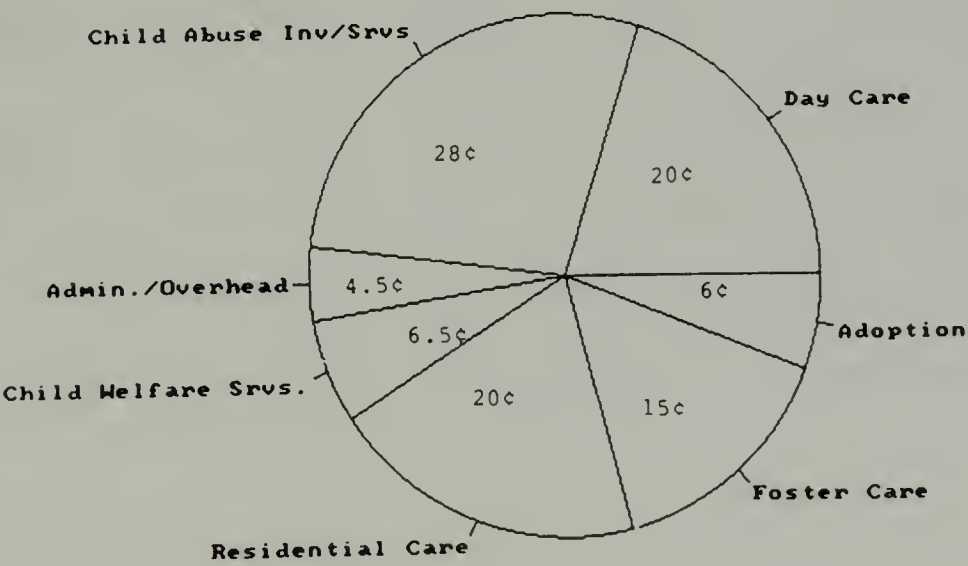
- More and more resources are being diverted from proactive child abuse prevention and intervention services into narrower and reactive child protection services and even those services are being reduced.

Where Each DSS Dollar Is/Will Be Spent

FY '90 (\$415m)



House 1 FY '91 (\$383m)



Our History/Our Future - A Brief Comparison

	FY '80	7/15/89	FY'90 est.	FY'91 est.
Workload				
Children reported Abused/Neglected	15,000	N/A	74,000	85,000
Families on Active Caseload	16,000	22,581	25,000	26,750
Children in Foster Care	7,593	7,783	8,200	9,000
Children in Group Care	1,611	1,602	1,710	1,750
Children in Supported Adoptions	1,160	3,614	4,009	4,500
Day Care Slots	14,000	20,738	18,234	15,234
Staffing				
Direct Service Staff	1,637	1,879	1,879	2,045
Support Staff	<u>1,098</u>	<u>738</u>	<u>653</u>	<u>653</u>
Total Staff	2,735	2,617	2,532	2,698
Organization				
Regional Offices	6	6	0	0
Area Offices	40	40	26	26

Meeting the Challenge

- Learn from our success in dealing with child sexual abuse. Fortunately, the tragedy of the California McMartin case has not happened in Massachusetts because we:
 - forged a strong relationship between District Attorneys and DSS by the passage of Chapter 288;
 - developed aggressive protocols for interviewing children; and
 - developed a comprehensive service response system for the child victim, other siblings, and the uninvolved caretakers.
- Not get overwhelmed by the fact that substance abuse affects five times as many children as child sexual abuse.
- Aggressively challenge child welfare, law enforcement and the judiciary to craft a response (see attached Project Protect) which recognizes that substance abuse is an extremely serious mother/child problem.

FFY'91

IV-B PLAN

CHAPTER II

Overview of Consumer Population

Served by the Department of Social Services

II. Overview of Consumer Population Served by the Department of Social Services

1. Introduction

The Department of Social Services is the state agency that is designated to provide social services to children and families in Massachusetts. These services are provided either directly by Department staff in twenty-six Area and four Field Support Offices, or through private providers from whom the Department purchases services. Consumers may receive both direct and purchased services while living either at home or in a substitute care placement. Children receiving DSS services may be under parental or guardian supervision, or may be in the care and custody of the Department.

This section provides an overview of the population served by DSS in FY'90 and compares it to a similar overview of the FY'89 consumer population as described in last year's plan. We are therefore able to look at the characteristics of the present consumer population as well as discern trends and changes which have occurred over the past year.

All of the data which follow were compiled from the Department's automated system, ASSIST (Area-based Social Services Information System Technology).

II. Overview of Consumer Population Served by the Department of Social Services

ASSIST is an on-line system being developed according to DSS's system development plan. DSS has implemented three modules: Consumer Registration, Consumer Tracking, and Resource Management, which are providing us with critical data about our consumers. During FY'88, authorization and payment functions were added for some DSS services. ASSIST is envisioned as a comprehensive system which, when fully implemented, will integrate modules related to vendor payments, human resources, and financial management.

2. Consumers and Families Served by DSS staff

Volume: The total DSS caseload at the end of June 1990 was 24,946 families (see Table 1). There were 45,397 children under 18 years old in the caseload at that time. Compared to June 1989, the total caseload increased by 11% (2,504 families) while the number of children rose by 12% (4,900) (Table 1). The growth in the caseload was substantially higher than the increase that took place from FY'88 to FY'89 (+ 3% for families and + 4% for both children under 18 years old and total consumers).

The number of children with supported (substantiated) sexual abuse investigations increased by 6% between calendar years 1988 and 1989 (Table 7B); this was the first annual gain

II. Overview of Consumer Population Served by the Department of Social Services

2. Consumers and Families Served by DSS staff (continued)

since 1985. For all forms of maltreatment, the total number of children with supported findings rose 21% from 1988 to 1989 (Table 7B). In contrast, the 1987 to 1988 expansion was only 9%. The first half of 1990 showed a 16% increase over 1989 in the number of children reported for all types of maltreatment.

Location: Children may receive services from the Department of Social Services either while living at home or while in substitute care placements. The breakdown by location of children in the DSS caseload remains generally consistent with that of a year ago. Table 2 shows that, on June, 1990 children under 18 years old who received services while remaining at home represented 76% of those in the DSS caseload, continuing the trend of previous years. Of the 24% of the child caseload who are in a substitute placement rather than at home, 81% are placed in family foster care, 13% in community residences, and 6% in other locations. The percentages show that, like last year, most children in DSS care and custody live in a family setting.

Adoption subsidies are paid by the Department to adoptive parents of children with special needs who might otherwise not find adoptive placement. These special needs include age, physical or emotional disability, and sibling-group size. Subsidies are also available for promoting minority adoptions.

II. Overview of Consumer Population Served by the Department of Social Services

Age of Individuals in Placement:

Table 3 and Figure 1 illustrate the age distribution of individuals in placement. The largest group is comprised of children between the ages of twelve and eighteen (36%). However, this adolescent group, as a proportion of all children in placement, is declining as the 0-5 year old group grows.

The age distribution of children in placement varies according to the type of placement (Table 4). This year's data show an increase over last year of all children in placement. The proportion of children who are under 12 years old accounted for 67% of the foster care population as compared to 64% a year ago (Table 4).

In contrast, community residences have a greater proportion of older (over 12 years) children (85% in 1990) than does foster care (33%). For each age group, a greater number of children are placed in foster homes than in community residences (Table 4).

Of the individuals in foster care and community residence placement on June 1990, 59% were under twelve years old (compared to 56% the previous year) and 35% were twelve to eighteen years old (compared to 37% last year (Table 4). The remaining 6% of consumers in placement were over eighteen, but continue to need placement services.

II. Overview of Consumer Population Served by the Department of Social Services

Length Of Time In Placement: The total number of individuals in foster care homes and community residences increased by 15% over the past year (Table 4). The proportion of children in these substitute care placements for more than two years as of June 1990 (31%) declined slightly since last year (33%) (Table 5).

Changes in Subsidized Adoptions:

If a child must be removed from the home and it is subsequently determined that he or she cannot be returned home, a permanent home is sought for the child. There was a 10% increase in adoption subsidies from 3,063 at the end of June 1989 to 3,358 in FY 1990 (Table 6). The agency's growing number of subsidized adoptions is indicative of the continuing success in securing adoption placements for children with special needs who might otherwise have remained in substitute care on a long term basis.

During FY'89, 589 adoptions were finalized for children in DSS care and custody, an increase of 10% over FY'88. Seventy-nine percent of these adoptions were facilitated through the provision by DSS of an adoption subsidy. (FY'90 adoption statistics will be available in January, 1991.)

Profile of Children Abused and Neglected: Department projections show an increase of 16% in 1990 of children who were reported maltreated, and an increase of 26% of children whose investigations resulted in a supported finding (Table 7A).

II. Overview of Consumer Population Served by the Department of Social Services

For the first half of 1990, 41,035 children were reported and 14,017 had supported findings as compared to 35,259 and 11,089 in 1989.

Data from Table 7B show that in 1989, the number with a supported finding of sexual abuse represented 12% of all children with supported investigations of maltreatment statewide. Among DSS Service Areas, this percentage varied from 4% to 22%. From 1988 to 1989, the number of children with supported findings of sexual abuse rose by 6% (Table 7A). This is the first significant annual increase since 1985.

3. Conclusions

The overview of the DSS consumer population at the end of FY 1990, and comparison to similar data from the previous fiscal year, reveal certain areas in which progress has been made or where certain trends are indicated. Each of these suggests future directions of DSS planning efforts.

Some of the key findings are:

- o The majority of children in the DSS caseload continues to be those who receive services while living at home. This observation underscores the Department's efforts to strengthen its supportive, preventive and reunification services to children and families at home.
- o Children who are over 12 years old no longer represent more than half of the children in placement. The proportion has decreased over time from slightly over 50% in 1984 to 43% in 1990. The Department has been successfully implementing new ways of giving these children stability through legal guardianship programs or by helping them to make a transition to independent living. Supportive/ preventive programs have been targeted to this group. Guardianships continue to increase (262 in FY'89).

II. Overview of Consumer Population Served by the Department of Social Services

- o The total DSS caseload increased significantly in FY'90, showing an 11% increase over FY'89. This was also reflected by a 12% growth in the number of children.
- o The number of children under 18 years old in foster care and community residential placements increased by 16% over last year.
- o The total number of children in placement increased by 12% from 1989 to 1990. Community residence placements showed a 1% decrease while foster care placements increased by 19%. The Department has closely monitored trends in these placements over the year, in order to assure that those children in need of placement are appropriately placed, with appropriate service planning and review.
- o The numbers of children reported and with supported investigations of maltreatment have increased. During 1989, investigations which resulted in a supported finding of sexual abuse represented 12% of all supported investigations statewide. The Department will continue to provide new and on-going outreach, prevention, and treatment services for abuse and neglect in general and sexual abuse in particular.
- o The number of children with supported investigations of sexual abuse increased by 6% from 1988 to 1989. The Department continues to provide several abuse treatment programs and to monitor and evaluate the utilization and effectiveness of these contracts in order to assure maximum availability of services to sexually abused children and their families.

The findings contained in the overview of the consumer populations, together with an assessment of FY 1990 goals, IV-B Assurances, and the DSS Needs Assessment process, have helped guide the Department in setting goals and priorities for long-range strategy, programs and policies.

TABLE 1. Total Caseload, Department of Social Services, June, 1989
and June 1990.

CASELOAD	FY 1989		FY 1990		CHANGE
	12/88	6/89	12/89	6/90	6/88 - 6/89
Families	21,073	22,442	23,181	24,946	2,504 (+11%)
Children (Under 18)	37,908	40,497	42,284	45,397	4,900 (+12%)
Total Consumers	65,630	70,052	72,806	77,930	7,878 (+11%)

SOURCE: 'Family Count by Area and Region' (ASSIST Report NTDSS819)
(Run-Dates: 12/17/88, 6/16/89, 12/16/89, 6/16/90) and 'Count
of Active Consumers by Age and Placement Type' (ASSIST Report
NTDSS809A) (Run-Dates: 12/16/88, 6/16/89, 12/15/89, 7/26/90).

TABLE 2. Location of clients in the caseload, Department of Social Services,
June, 1989 and June, 1990.

LOCATION	June, 1989		June, 1990	
CHILDREN UNDER 18				
Children in Placement:				
Foster Care	7,495	(79%)	8,936	(81%)
Community Residence	1,436	(15%)	1,389	(13%)
Other (*)	613	(6%)	683	(6%)
Subtotal:	9,544	(100%) (24%)	11,008	(100%) (24%)
Children not in Placement:	30,953	(76%)	34,389	(76%)
TOTAL UNDER 18 IN CASELOAD:				
	40,497	(98%) (100%)	45,397	(98%) (100%)
18+ YEARS OLD IN PLACEMENT				
	740	(2%)	848	(2%)
TOTAL IN CASELOAD:				
	41,237	(100%)	46,245	(100%)

SOURCE: Count of Active consumers by Age and Placement Type (ASSIST Report NTDSS809A, Run-Dates 6/16/89 and 7/26/90). ASSIST counts of children residing at home include some children in the custody of DSS.

(*) "Other" includes children in pre-adoptive homes, supervised independent living, emergency shelters, institutions, and "on the run" from placement.

TABLE 3. Age of Individuals in Placement, Department of Social Services
June, 1989 and June, 1990 (*)

AGE (years)	June, 1989		June, 1990		Change 6/89 - 6/90
0 - 5	2,451	(24%)	3,133	(26%)	(+28%)
>5 - 12	3,143	(31%)	3,642	(31%)	(+16%)
>12 - 18	3,950	(38%)	4,233	(36%)	(+7%)
>18 - 22	688	(7%)	759	(6%)	(+10%)
> 22	52	(1%)	89	(1%)	(+71%)
TOTAL	10,284	(100%)	11,856	(100%)	(+15%)

(*) Placement locations are foster care, community residence, pre-adoptive home, supervised independent living, emergency shelter, institution, and "on the run" from placement.

Note: Total percentages may not add to 100% due to rounding-off.

SOURCE: Count of Active Consumers by Age and Placement Type (ASSIST Report NTDSS809A, Run-Dates 6/16/89 and 7/26/90).

TABLE 4. Age of Individuals in Foster Care and Community Residence,
Department of Social Services, June, 1989 and June 1990.

Age (years)	June, 1989			June, 1990		
	Foster Care	Community Residence	Total	Foster Care	Community Residence	Total
0 - 5	2,340	7	2,347	2,988	6	2,994
> 5 - 12	2,727	308	3,035	3,284	239	3,523
> 12 - 18	2,428	1,121	3,549	2,664	1,144	3,808
> 18	382	225	607	411	248	659
Total	7,877	1,661	9,538	9,347	1,637	10,984

SOURCE: Count of Active Consumers by Age and Placement Type (ASSIST Report NTDSS809A, Run-Dates 6/16/89 and 7/26/90).

TABLE 5. Length of Time of All Individuals in Foster Care and Community Residence, Department of Social Services, June, 1989 and June, 1990.

June, 1989						
Length of Time in Placement	Foster Care		Community Residence		Total	
0 - 12 months	3,702	47%	615	37%	4,292	45%
> 12 - 18 months	1,024	13%	233	14%	1,240	13%
> 18 - 24 months	709	9%	149	9%	858	9%
> 24 months	2,442	31%	664	40%	3,148	33%
TOTAL	7,877	100%	1,661	100%	9,538	100%

June, 1990						
Length of Time in Placement	Foster Care		Community Residence		Total	
0 - 12 months	4,273	46%	606	37%	4,879	44%
> 12 - 18 months	1,340	14%	234	14%	1,574	14%
> 18 - 24 months	910	10%	162	10%	1,072	10%
> 24 months	2,824	30%	635	39%	3,459	31%
TOTAL	9,347	100%	1,637	100%	10,984	100%

NOTE: These tables include individuals over 18 years old.

SOURCE: Continuous Time in Placement by Age and Current Placement Type (Active Consumers) (ASSIST Report NTDS495A, Run-Dates 6/30/89 and 7/26/90) and Count of Active Consumers by Age and Placement Type (ASSIST Report NTDSS809A, Run-Dates 6/16/89 and 7/26/90).

TABLE 6. Changes in the Numbers of Individuals in Foster Care and
Community Residence and Those Receiving an Adoption Subsidy,
Department of Social Services, June, 1989 and June, 1990.

	June, 1989	June, 1990	Change 6/88 - 6/89
Foster Care	7,877	9,347	1470 (+19%)
Community Residence	1,661	1,637	-24 (-1%)
TOTAL IN PLACEMENT	9,538	10,984	1446 (+15%)
SUBSIDIZED ADOPTION	3,063	3,358	295 (+10%)

SOURCE: ASSIST Subsidy Extract Disk File (Run-Date 6/30/89 and 6/29/90).

Count of Active Consumers by Age and Placement Type (ASSIST
Report NTDSS809A, Run-Dates 6/16/89 and 7/26/90).

TABLE 7A. Counts of Maltreated Children (*)

=====		
No. of Children	1989	1990 (est)

Reported	70,713	82,297

Investigated and a Supported Finding of Maltreatment	22,532	28,481

(*) Calendar Years 1989 and 1990

Note: 1990 figures are based on January - June, 1990 data, projected to 12 months.

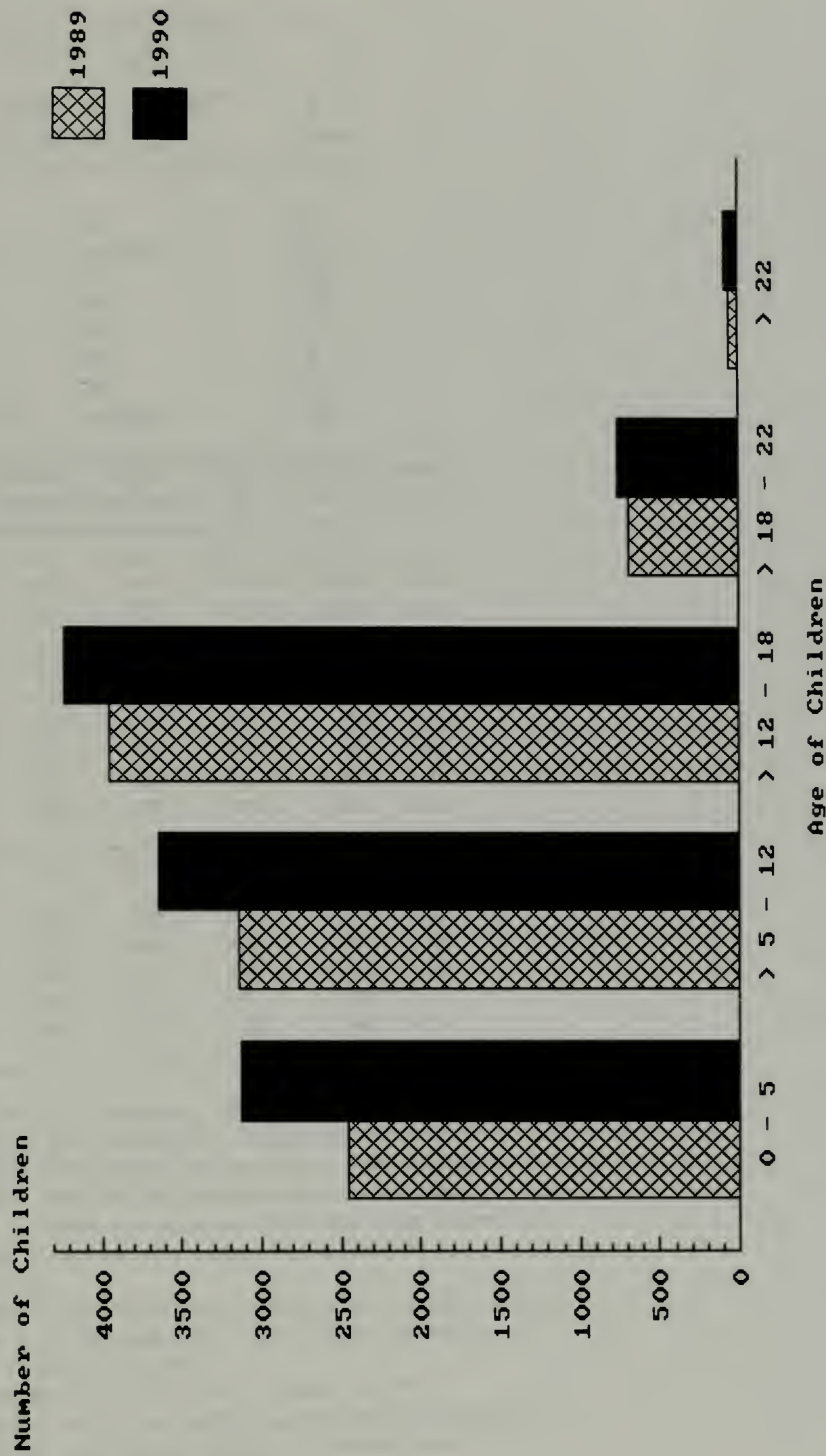
SOURCE: Monthly Report and Investigation Activity (ASSIST Report NTDSS742A, January - December 1989 and January - June 1990).

Table 7B. Children with Supported Investigations of All Maltreatment and Sexual Abuse during
January 1 - December 31, 1989 by Geographic Location.

Children with Supported Investigations					
Geographic Location	All Maltreatment No.	% Change 1988-89	Sexual Abuse No.	% Change 1988-89	Sexual Abuse as % of All Maltreatment
Pittsfield	504		66		13%
Greenfield/Northampton	479		89		19%
Holyoke/Westfield	1,179		114		10%
Springfield	961		102		11%
Fitchburg/Gardner	686		150		22%
South Central/Blackstone Valley	816		182		22%
Worcester	864		129		15%
PAS Agencies	927		132		14%
WEST	6,416	20%	964	15%	15%
Lowell	981		86		9%
Lawrence	660		40		6%
Haverhill/Cape Ann	642		74		12%
Lynn	734		53		7%
Eastern Middlesex/Tri-City	463		77		17%
Framingham/Marlboro	615		80		13%
Cambridge-Somerville/Arlington	668		75		11%
Waltham	295		39		13%
PAS Agencies	875		86		10%
NORTHEAST	5,933	26%	610	5%	10%
Quincy/Weymouth	490		70		14%
Attleboro/Taunton/Norwood	831		104		13%
Brockton	1,154		144		12%
Fall River	736		100		14%
New Bedford	968		168		17%
Cape & Islands/Plymouth	716		131		18%
PAS Agencies	554		76		14%
SOUTHEAST	5,449	23%	793	9%	15%
Morton Street	1,018		55		5%
Dimock Street/Allston	926		63		7%
S.C.F. Mental Health Center	1,062		42		4%
Fields Corner	891		61		7%
Harbor/Charlestown/Chelsea	804		82		10%
PAS Agencies	506		33		7%
BOSTON/BROOKLINE	5,292 (*)	17%	340 (*)	-17%	6%
STATE	23,090	21%	2,707	6%	12%

(*) = Includes investigations completed by the Boston Hot-line and Homeless Units.

**FIGURE 1. AGE OF INDIVIDUALS
IN PLACEMENT
JUNE, 1989 AND JUNE, 1990**



Research, Evaluation and Planning Unit
Massachusetts Department of Social Services
Source: ASSIST Report NTDSS809A

INDICATOR	TOTAL FY89	TOTAL FY90	2 YEAR TOTAL	CHANGE YR1-YR2
EMERGENCY RPTS INVSTGT'D	1633	1791	3424	+10%
Investigated in 1d	1534	1649	3183	+7%
NON-EMRGNCY RPTS INVSTGT'D	26,679	31,610	58,289	+18%
Investigated in 10d	25,237	29,407	54,644	+17%

INCREASE: JAN-JUNE, 1989

TO JAN-JUNE, 1990

1/90-6/90

CHILDREN/SUPP'D INVSTG'NS:

Open for services	26%	9264
Percent open for services	no change	65%
Continue services	26%	3659
No services req'd	14%	1159
Unable to locate family	46%	54
Refer for voluntary	52%	38
All children/supp'd	25%	14,174
Percent receiving services	no change	91%

	%CHANGE FY88-FY89	%CHANGE FY89-FY90	%CHANGE IN 2 YRS	CURRENT LEVEL	CHANGE YR2/YR1
CONSUMERS - TOTAL	+4%	+11%	+15%	77,930	2.8x
Not in placement	+3%	+11%	+13%	66,074	3.7x
In placement	+9%	+15%	+26%	11,856	1.7x
w/Relative	+20%	+31%	+56%	2,216	1.6x
Unrelated foster care	+10%	+15%	+26%	7,131	1.5x
Adoptive home	-13%	+24%	+6%	250	2.8x
TIL	+1%	+36%	+47%	198	36x
CRS	+3%	-1%	+1%	1,637	0.3x
Institution	-12%	+28%	+18%	114	3.3x
CONSUMERS IN PLACEMENT	+9%	+15%	+26%	11,856	1.7x
0-2 years old	+29%	+24%	+59%	1,172	0.8x
>2-5 years old	+16%	+30%	+51%	1,961	1.9x
>5-12 years old	+17%	+16%	+35%	3,642	0.9x
>12-18 years old	+11%	+7%	+8%	4,233	7x
>18 years old	-4%	+15%	+10%	848	4.8x

Observations:

1. Screened in reports are still increasing (+18% in FY90); 10d investigation compliance is keeping up, but 1d emergency investigations are not.
2. Children with supported investigations increased 26% in FY90; the same proportion are receiving services; the same proportion are new cases.
3. The rate of increase in consumers in caseload in FY90 was almost 3 times that of FY89; the rate of increase of consumers in placement was almost twice that of FY89.
4. The largest FY90 increase in placements was children in the 2-5 year old range placed with relatives or in unrelated foster care. Relative placements are increasing twice as fast as unrelated.
5. There was a marked increase in institutional placements in FY90; however, CRS held steady, and TIL and adoptive home placements also went up.
6. There has been a reversal of the previous decline in consumers over 18 in placement; all age groups are now increasing.

FFY'91

IV-B PLAN

CHAPTER III

NEEDS ASSESSMENTS

III. NEEDS ASSESSMENT

From 1986 through 1989, the Department of Social Services compiled, on an annual basis, an extensive Needs Assessment Resources package, which was then distributed to Field Support and Area Offices in the Spring, for their use in preparing future area plans. These materials were designed to provide quantitative, comparative data for the areas about their populations, consumers and services.

In FY'90, the Department elected to conduct issue-specific Needs Assessments. Rather than compiling general demographic and socioeconomic data, targetted Needs Assessments have been conducted regarding Substance Abuse services and Mental Health services.

A copy of the Substance Abuse study, entitled "Need and Availability of Substance Abuse Services for DSS Consumers" follows. A copy of the preliminary findings of the Mental Health Needs Assessment is enclosed. When the final report is issued, copies will be forwarded to DHHS staff.

In addition to the information gathered through these issue-specific Needs Assessments, the Department's Research, Evaluation and Planning Unit compiles and analyzes data of particular interest to field staff. Among the reports issued in FY'90 were: Annual Demographic Report on Consumer Populations, issued in July, 1989 and 1989 Child Maltreatment Statistics, issued in June 1990 (copy follows).

These reports are shared with Executive Staff, Field Support Directors, Area Directors and Partnership Agency Directors. Along with the Needs Assessments, these reports will assist the Agency with its planning, monitoring and budgeting process.

During FY'91, specific assessment and analysis will be conducted regarding the Agency's new Project Protect program, and the effectiveness of Parent Aide Services.

Need and Availability of Substance Abuse Services for DSS Consumers

October, 1989

**Commonwealth of Massachusetts
Michael S. Dukakis, Governor**

**Executive Office of Human Services
Philip W. Johnston, Secretary**

**Department of Social Services
Marie A. Matava, Commissioner**

Need and Availability of Substance Abuse Services for DSS Consumers

Magueye Seck, Evaluation Specialist

Sean Parkins, Policy Intern, and

**Julia Herskowitz, Director
Research, Evaluation, and Planning Unit**

**James L. Bell, Assistant Commissioner
Office for Professional Services**

**Marie A. Matava, Commissioner
Department of Social Services**

October, 1989

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Substance Abuse Services For
DSS Consumers**
- * **APPENDIX A:
Area and Social Service
Center Summaries**
- * **APPENDIX B:
Area and Survey Instrument**

NEED AND AVAILABILITY OF SUBSTANCE ABUSE SERVICES FOR DSS CONSUMERS

INTRODUCTION

This problem (drug and alcohol abuse) is not limited to one age group, sex, social class, or racial or ethnic group any more than it is restricted to one type or category of drug. (Kelleher, Murray, Shapiro, 1983).

Recent reports on substance abuse have dealt extensively with physiological effects, intervention, and prevention of drug and alcohol abuse, yet there is scarce information about the social impact of parental use of drugs and alcohol on infants and children. The Massachusetts Department of Social Services, like other child welfare agencies across the country, has focused on this problem more than almost any other over the past year. One result of this increased attention has been Project Protect, a combined policy statement and procedural guidelines for caseworkers that deals with the issues of substance abuse and domestic violence in relation to child protective services. A related outcome was a study of the association of substance abuse with confirmed reports of child maltreatment in the city of Boston. A third aspect of the focus on substance abuse in relation to child protective services is reported below. It is a summary of an assessment of the needs of families, in the Department's caseload, that are affected by the use of drugs and alcohol. In doing so, the needs of the family as a unit are considered, rather than those of the abuser alone, because of the impact of substance abuse on the health and safety of the children.

The Massachusetts Department of Social Services (DSS) had been receiving anecdotal evidence linking the increasing drug use in communities throughout the state to the escalating number and increasing level of violence in child abuse cases. This evidence had influenced the DSS to further investigate the association of substance abuse with child abuse reports, leading to a study of

the problem in a more systematic fashion. An initial incidence study in Boston (Herskowitz, Seck, and Fogg, 1989) indicated that two-thirds of all supported reports of child abuse and neglect were associated with substance abuse. The pattern of substance abuse in the Boston study indicated use of cocaine by a family member in 42% of the of supported reports sampled. Excessive alcohol use was reported in 31% of the investigations. Multidrug use was very common. Only in 36% of the cases was no substance abuse identified. Although the Boston study did not support or contradict views that associate increased cocaine usage and serious physical abuse of children, it did indicate a consistent problem of severe and chronic neglect of young children whose parents were addicted to cocaine. In many cases, the neglect included a total lack of food, milk, or diapers in the house. Medical and educational neglect, as well as lack of supervision and even abandonment of young children by drug users, were also identified in the investigations of maltreatment.

A similar study of a statewide sample of supported reports of child abuse and neglect is being conducted currently. Initial indications are that, in Massachusetts, substance abuse by caretakers is a concurrent factor in about two-thirds of the cases of children with supported reports for physical abuse, neglect, or emotional maltreatment. On an annual basis, close to 20,000 children are the subjects of over 13,000 supported investigations of abuse and neglect.

In contrast to the above numbers, there were about 900 DSS referrals to the Department of Public Health's (DPH) drug and alcohol services in fiscal year 1989 (up 13% from FY88). DSS referrals to DPH providers were different from referrals from other community sources. For example, the mean age of the DSS-referred group was 26 years versus 35 years for all referral sources. Sixty-eight percent of DSS clients referred to DPH for drug and alcohol treatment were female (versus 24% for other referral sources). DSS clients were also more likely to be

referred for use of cocaine and crack (28%), than were other sources of referrals (21%). DSS was clearly the principal referral source for adolescents and young adult women. On the other hand, these two groups were a small proportion of all referrals to DPH substance abuse services.

All DSS Area Directors were surveyed in order to ascertain to what the difference between referrals for treatment and the number of DSS families in need of such services was due. The survey results are reported below.

METHODOLOGY

In assessing the needs for and the availability of drug and alcohol treatment services, an instrument was designed to ascertain the extent and kinds of resources needed by DSS social workers in order for them to provide help to DSS families affected by drug and alcohol abuse. (See Appendix B.) Respondents were asked to rank both the need and availability of substance abuse treatment services for DSS consumers. Services ranged from detoxification to residential treatment, outpatient services, and self-help groups. Access to various services for the type of client was also examined, e.g., adult men, adolescents, mothers with and without child care needs, pregnant women and teens, and battered women.

In addition to service need and availability, the survey was designed to characterize what supports were available to area staff. Respondents were asked to rank their needs for training in the following areas: (a) diagnosis, assessment, and development of service plans; (b) locating or utilizing treatment resources; (c) identifying risk factors to children; (d) dealing with resistant or hostile clients; (e) the impact of substance abuse on family functioning; and (f) cultural issues. Similarly, respondents were asked to evaluate the assistance, protection, or support to DSS families from other (non-DSS) community agencies.

The surveys were sent to all Area Directors, who were requested to join their efforts with area program managers, supervisors, and others to assess the size and nature of the drug and alcohol problems in their caseloads and the need and availability of substance abuse treatment services in their areas. After completion and return of thirty-eight surveys (out of forty), the needs assessment data were analyzed for:

- * the estimated percentage of open cases involving drugs or alcohol;
- * the estimated percentage of supported abuse and neglect reports involving drugs or alcohol;
- * what and how much DSS staff do and do not know about substance abuse-related problems;
- * the consumer groups most in need of drug and alcohol services;
- * the availability of drug and alcohol treatment services for DSS consumers in each area; and
- * the severity of need based on waiting time, rejections, and other data kept by the areas.

SURVEY RESULTS

PERVASIVENESS OF SUBSTANCE ABUSE IN THE DSS CASELOADS

Area responses indicated that most open cases as well as the majority of child maltreatment reports include substance abuse as a factor. Eighty-seven percent of the area responses (33 areas) indicated that over 50% of the families in open cases are drug and/or alcohol involved. Nine areas (24%), primarily among the most urbanized, found 75% and more of their cases as alcohol/drug related. The more suburban Framingham and Weymouth Areas were included in this group, however. Only 13% (5 areas) estimated that 25% to 50% of their cases were drug/alcohol related. Surprisingly, the Holyoke and Worcester Area Offices were in this

group; the other areas were primarily suburban communities. None indicated less than 25% involvement. (See Figure 1.)

The areas estimated that a somewhat smaller percentage of supported child abuse and neglect reports were associated with drug and alcohol abuse. Seventy-six percent of the areas estimated substance abuse as a factor in 50% or more of child abuse and neglect (CA/N) reports. In half the areas, supported CA/N reports involved with alcohol or drugs ranged between 51% and 75%. Two areas, suburban Norwood and Blackstone Valley, reported less than 25% of their supported reports and ten areas, again mostly highly urbanized, reported over 75% of their supported cases as substance abuse-related. (See Figure 2.)

KNOWLEDGE AND TRAINING NEEDS

One-fourth of the areas responding had no resource directories available for staff. Of the 76% who did, few were current. The most common directories were those issued by the Department of Public Health (DPH) and the Massachusetts Bar Association, and the Human Services Yellow Pages. Since this survey was completed, however, current DPH resource directories have been distributed to all DSS sites although not in the quantity needed. It is anticipated that a more updated version of the DPH directory will be available to all case managers in November, 1989.

Further staff training on substance abuse issues is clearly desired by the majority of areas. One office reported staff as being "very knowledgeable" about problems related to substance abuse; eight thought staff were "knowledgeable;" and the remainder were "somewhat knowledgeable, but wanted more training."

The areas of training (concerning substance abuse) that were cited as most important were: identification of risk factors (66%); diagnosis, assessment, and development of service plans

Figure 1. PERCENT OPEN CASES IN DSS AREAS INVOLVED
WITH SUBSTANCE ABUSE
N = 38

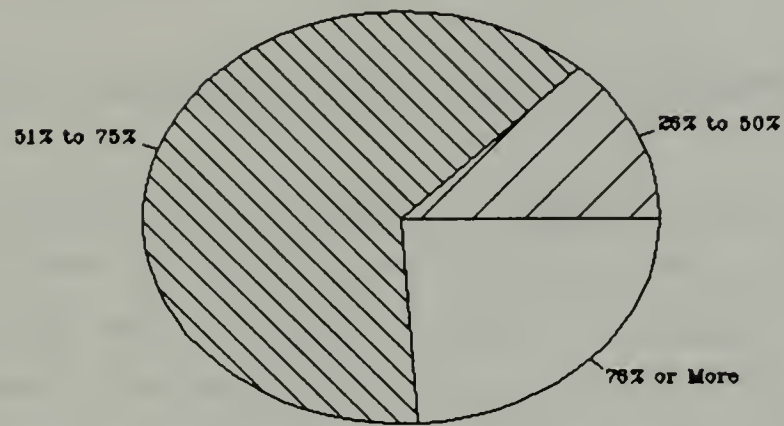
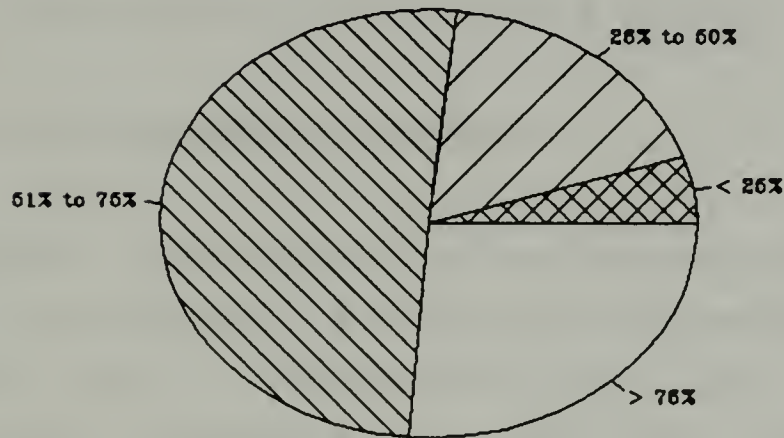


Figure 2. PERCENT OF SUPPORTED A/N REPORTS
INVOLVED WITH SUBSTANCE ABUSE
IN DSS AREAS



(53%); impact of substance abuse on family functioning (53%); and dealing with hostile/resistant clients (42%). Respondents thought that training about locating resources (15%), and training about cultural issues (5%), were less important.

SERVICES/HELP FOR CHILDREN AFFECTED BY SUBSTANCE ABUSE

The respondents were asked to rate the ability of various community resources in providing assistance to children affected by substance abuse and related family violence. The rating was scaled as follows: "excellent," "very good," "good," "fair," and "poor." Respondents indicated that the health care system was the most supportive; 55% of the respondents gave it a "good" or better rating. Also with "good" or better ratings in about half the areas, were the schools (50%), the police (50%), and the courts (47%).

The Areas assessed the private social service agencies, extended families, cultural and religious institutions, the mental health system, and friends to be generally "fair" supports. Only employers were rated primarily "poor" as community resources in providing help to children affected by their caretakers' problems with alcohol and drugs.

AVAILABILITY OF TREATMENT RESOURCES

The overall availability of resources was described as "available, but difficult to obtain" statewide (Figure 3). Long waiting lists, lack of medicaid eligibility, and the lack of other third party insurance were the most frequently cited barriers to service delivery.

Figure 3. OVERALL AVAILABILITY OF TREATMENT RESOURCES

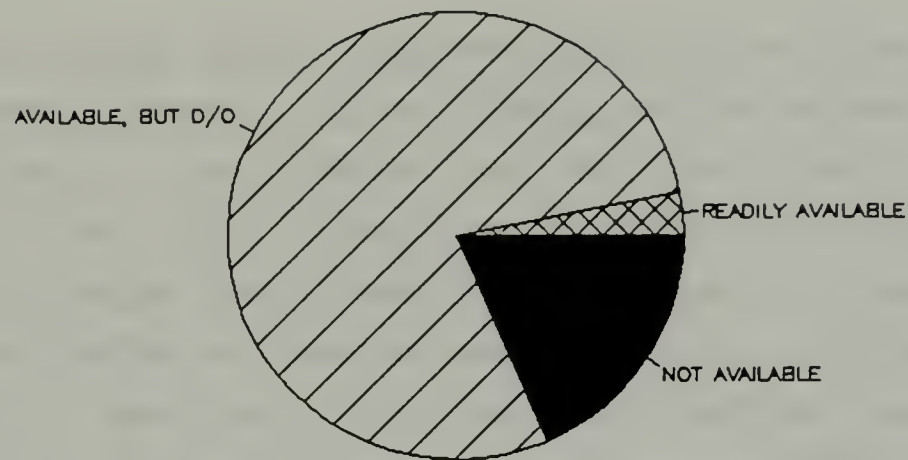
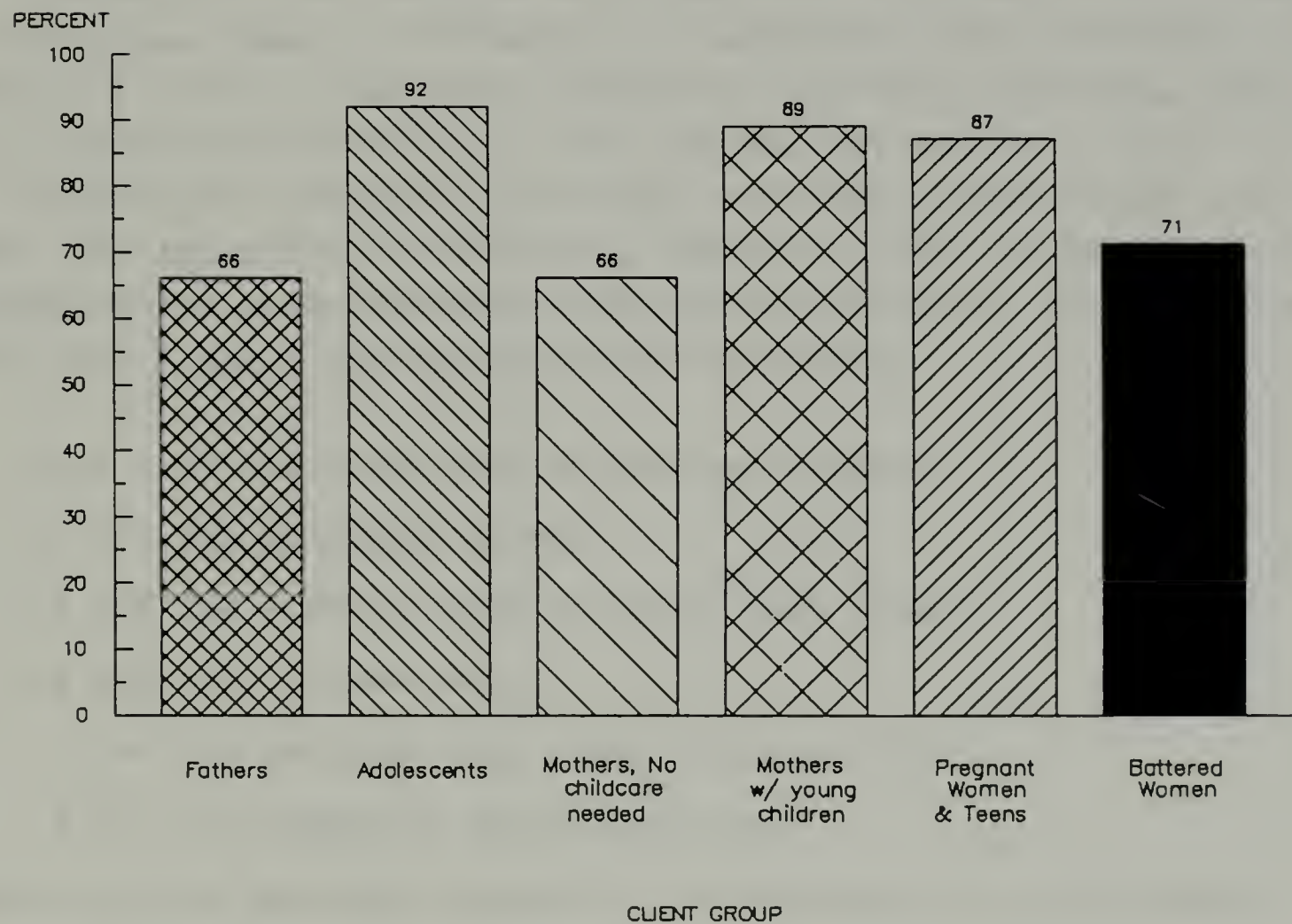


Figure 4. AREAS WITH INADEQUATE TREATMENT RESOURCES



DRUG TREATMENT

Areas were asked about the availability of drug treatment services to area clients. Classifications for answers were "readily available," "available, but difficult to obtain," "not available," or "not sure" (about their availability).

Self-help groups comprised the only service modality, that was readily available to most consumer groups. The self-help groups, Narcotics Anonymous, ALANON, and ALATEEN were "readily available," in the majority of areas. However, Cocaine Anonymous was readily available in less than 30%, and unavailable or the respondent was not sure if it was available in 55%. Cocaine Anonymous (CA) is not as well established as other self-help groups and CA groups are not, as yet, as well known to DSS staff or consumers.

Detoxification centers and outpatient treatment facilities for drug use were "available" or "available, but difficult to obtain" in 76% of the areas; inpatient services were "available, but difficult to obtain" in 66%, and halfway houses in 55%.

Community residential services for drug abusers were the least available service modality. Regarding the groups of consumers for whom community residential services (CRS) were "not available," the areas reported the following:

- 50% of the areas had no CRS for fathers;
- 58% for battered women;
- 58% for mothers with no child care needs;
- 66% for adolescents;
- 76% for mothers with young children; and
- 82% for pregnant women and teens.

Only one area reported community residential services readily available, but only for fathers.

ALCOHOL TREATMENT

Similar to the drug treatment responses, the areas indicated that self-help groups for alcohol treatment were "readily available" [Alcoholics Anonymous (84%) and ALATEEN (71%)].

Alcohol detoxification centers were "readily available" in 32%, twice the percentage of drug detoxification facilities. Alcohol detoxification centers were "available, but difficult to obtain" in 55% of the areas.

Both inpatient and outpatient treatment services were reported "available, but difficult to obtain" by 60% and 65% respectively. In ten areas, inpatient treatment facilities were not available at all. Halfway-houses were "available, but difficult to obtain" in 58% of the areas and fourteen areas (37%) claimed non-availability.

As with drug treatment, community residential treatment services were the least available. Concerning the groups of consumers for whom community residential services were not available, the areas reported the following:

- 50% of the areas had no CRS available for fathers;
- 50% for mothers with no child care needs;
- 55% for battered women;
- 63% for adolescents;
- 63% for mothers with young children; and
- 76% for pregnant women and pregnant teens.

CONSUMER GROUP ANALYSIS

Respondents in 95% of the areas agreed that the needs for treatment services for mothers with young children were the most severe relative to the other groups. The second highest need for alcohol and drug services was attributed to adolescents (71%).

However, the needs of pregnant women and pregnant teens ranked surprisingly low, with only 37% of respondents who thought the needs of this group were high relative to others. Alcohol and drug treatment centers throughout the state have been very reluctant to take pregnant women, because of possible medical problems and legal liability issues. The low needs ranking given this group may be due more to the even higher needs of women with young children and of adolescents, rather than being a low absolute need.

According to recent research, the effects of alcohol, cocaine, heroin, marijuana and other drugs on fetuses and newborns include prenatal strokes, tremors, motor, cognitive, and emotional deficiencies, low birth weight, fetal death, and prematurity. These undesirable fetal outcomes alone are a reason to accept pregnant women into treatment programs. The lack of community residential services for pregnant and parenting women, particularly those that allow women to keep their older children and/or infants with them, is even greater. Only two such programs exist, one in Somerville and one in Boston. A third, for Latina women, is scheduled to open soon in Boston.

Non-pregnant women with young children face an even more severe problem. Only one program that allows children to stay with their mothers is available now. Another six programs, with a statewide distribution, for homeless, substance abusing women and their children are planned. Residents would remain six to nine months for treatment and support services. The first may open as soon as next winter. At maximum capacity, however, the six programs together will house 35 to 45 families at any one time.

Respondents indicated high needs for drug and alcohol services for battered women in only 8% of the areas. This statistic should not be interpreted in a way that minimizes the significance of the substance abuse problems of battered women, because ranking was used to describe the relative priorities of

the needs of the various groups, not the absolute level of need of any one group.

Similar to the issues of pregnant women and pregnant teens, battered women with young children have also not been getting the drug and alcohol treatment services they need. In addition, battered women's shelters are lacking resources and are frequently so overwhelmed trying to provide space and protection, they cannot deal directly with residents' needs for alcohol and drug treatment. Too few provide substance abuse treatment as an integral part of their program.

Alcohol and drug treatment services were found to be generally lacking. At the high end of availability, 29% of the areas found resources for fathers adequate and 24% believed them to be adequate for mothers with no child care needs. On the other hand, 92% of the areas reported inadequate resources for adolescents; 89% for resources for mothers with young children, and 87% for pregnant women and pregnant teens. Finally, treatment services for battered women were viewed inadequate in 71% of the areas, confirming that the low percent of areas ranking this group in terms of high need was only indicating its relative position to other, even more needy groups. (See Figure 4.)

Alcohol and drug treatment services for mothers with young children are among the least available. Combined with the observation that this group is also the most in need for services, leads to the conclusion that the service system must concentrate its efforts on provision of resources to this group.

GEOGRAPHIC DIFFERENCES

Geographic differences were minimal. Half the areas in central Massachusetts reported that 50% or less of their open cases were alcohol and/or drug involved. Areas in all other parts of the state showed higher percentages of alcohol and drug abuse

related to their cases. The supported child abuse and neglect reports involved with drugs and alcohol indicated similar patterns: in all sections of the state, with the exception of central Massachusetts, the majority of the areas reported that more than 51% of supported reports had drug and alcohol involvement. Conversely, the Boston and metropolitan Boston areas indicated extremely high percentages (76% or more) in both their open cases and their supported reports, that were alcohol and drug related.

No geographical differences have been found in terms of the areas' overall needs for services. Areas from all parts of the state indicated that services, which were available to them, were also difficult to obtain. Only in one area of western Massachusetts were services reported as readily available.

One respondent's statement helps illuminate the barriers to providing treatment services:

Out of six families who agreed to be referred for substance abuse treatment, two went to treatment. Both of these clients had to wait 2 to 3 weeks for a bed. The other four had to wait 5 weeks, became re-involved with drug-taking friends, and refused to go to treatment when a bed became available.

Social workers and supervisors find this type of situation "very discouraging." Recent regulatory changes that allow Medical Assistance (Medicaid) payments for previously uncovered outpatient and detoxification services may help alleviate some shortages, as these services expand their capacity in response to the new funding source. The very acute shortages in residential treatment beds, however, are unlikely to be remedied in the near future.

In terms of staffing, areas from all parts of the state agreed that more training in substance abuse issues was needed for most of their staff. One area in southeast Massachusetts stated that its staff were very knowledgeable about substance

abuse-related issues. Overall, the need for further training of line workers in substance abuse issues is significant statewide.

Area and Social Service Center-specific summaries can be found in Appendix A.

SUMMARY AND RECOMMENDATIONS

* The Boston and statewide studies of child maltreatment cases, as well as the area needs survey, indicate a prevalence rate of 60 to 65% for drug and alcohol abuse among DSS cases. In addition, twice as many areas estimate a prevalence of over 75% as areas estimating a rate of under 50%.

* While most area staff have had some training on substance abuse issues, three-fourths of the areas report a need to increase their knowledge on substance abuse, particularly in the areas related to risk identification; diagnosis, assessment, and service planning; impacts on families; and intervention strategies.

RECOMMENDATION 1: Although there has been further training of area supervisors since the survey was issued, training may need to be expanded in the following ways:

- a) be made mandatory for all staff and made a higher priority area of pre-service training;
- b) be incorporated into in-service training with an initially high enough frequency so that all staff are able to attend over the next twelve months; and
- c) add to the above training [b)], the skills needed by case managers to do a preliminary assessment for drug and alcohol services.

* Outpatient counseling and outpatient detoxification (including methadone) are the second most available treatment modalities (after self-help) for all client groups, except perhaps adolescents. Furthermore, their availability will increase over the next year as they are now Medicaid-reimbursible and provider capacity will expand as a result. Acupuncture detoxification (for cocaine, heroin, and polydrug users) is also coming into greater use as an outpatient modality.

* Community residential services, particularly for women with child care needs, pregnant women and teens, and adolescents, is in the shortest supply. Some expansion for the first group is expected as there will be some additional capacity in the form of specialized shelters housing women in treatment and their children, but widespread expansion of community residential services is unlikely, given their cost.

Recommendation 2: If they have not already done so, Area and Social Service Center Directors should make an effort to get to know the Regional Managers from the DPH's Division of Substance Abuse Services. They are very knowledgeable both about treatment for substance abuse problems and about the providers in their respective Regions.

Recommendation 3.: Social workers should not consider residential care the only effective treatment. In many cases, outpatient detoxification and follow-up services, or outpatient services following an inpatient detoxification can be quite effective. More extensive use needs to be made of outpatient services - evaluation, counseling, acupuncture, methadone dosing, day treatment - alone and in combination with each other; inpatient detoxification; and where appropriate, ongoing monitoring for drug use by testing. To do so, it is necessary to know the local treatment system well (see Recommendations 2 and 4).

Recommendation 4: Current Department of Public Health directories for drug and alcohol services are now at all DSS service sites. Many more copies - hopefully one per case manager - should be there shortly. It is recommended that a designated area manager, for now, and eventually each social worker keep their directories annotated with up-to-date information on such factors as wait lists, special procedures for intake, quality of services as perceived by the consumer as well as the worker, personal contact information, and so on.

* Service availability varies by the treatment modality, as well as by the client group. Self-help groups (AA, NA, Alateen, etc.) are the most available modality to all consumer categories, probably because they are not dependent on public or private funding or on licensed providers. They are, however, very

effective services, especially in conjunction with other, more clinical treatments.

* Although self-help groups for different kinds of addictions are available and adequate in communities throughout the state, the cocaine-specific self-help groups (Cocaine Anonymous or CA) are less widely distributed and are not as well known within the DSS referral system. Cocaine is, however, the most frequently used drug by DSS consumers in Boston and a significantly used drug elsewhere in the state.

RECOMMENDATION 5.: There should be more referrals to and participation by DSS clients in Cocaine Anonymous. CA is not as widely available as AA or NA; also, DSS staff may not be as familiar with it. Central or area management staff should ascertain where CA groups are present and alert area Social Workers to their availability. Where they are not present, but needed, the CA parent organization can be contacted about starting up new groups. Also, a client recovering from a cocaine habit should not wait to attend a CA group; NA and even AA groups are likely to be as good for most consumers, as polydrug use is the norm rather than the exception and the "12-step" program is basically the same for each. Unavailability due to language can be dealt with in the same way as geographic unavailability (for NA or AA as well).

* The survey results indicated that while substance abuse treatment was predominantly seen as unavailable to battered women as a group, respondents also indicated that services to battered women were of a lower priority for the areas than for other groups. In other words, relative to women with child care needs, pregnant women, and adolescents, there was less of a need for services for battered women. This is most likely due to battered women being perceived, perhaps inaccurately, as a smaller group of DSS consumers than the others.

Recommendation 6: By itself, the occurrence of physical abuse of the mother of young children by a man in the household may be the most predictive risk factor for subsequent physical abuse of the child or children. At minimum, it is emotional maltreatment. Combined with drug or

alcohol abuse, by either adult, it is potentially very harmful to the children and the woman. Protection of the children is clearly the social worker's first priority in such cases. Removing the batterer or, if that is not possible, removing the children and their mother from the home together is preferable to removal of the children alone, if the mother is able to provide appropriate care for her child(ren).

If it is the mother that is in need of treatment for drug or alcohol abuse, as well as protection from the batterer, a battered women's shelter that provides treatment as well as protection, is desirable. Alternatively, if the mother and children can remain together at home (without the batterer) or go to a shelter that does not provide such treatment, substance abuse treatment should be arranged by her DSS case manager as soon as possible. As long as the mother is affected by the drugs, she will be unable to adequately protect or nurture her child(ren) without, at minimum, the support of a treatment program.

REFERENCES

Herskowitz, J., M. Seck, and C. Fogg 1989 Substance Abuse and Family Violence, Part 1: Identification of Substance Abuse During Child Abuse Investigations in Boston. Massachusetts Department of Social Services.

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APPENDIX A
AREA AND SOCIAL SERVICE CENTER
SUMMARIES

DEPARTMENT OF SOCIAL SERVICES
ALCOHOL AND DRUG TREATMENT NEEDS ASSESSMENT
AREA INFORMATION
July 31, 1989

The following summaries are derived from information acquired as a result of a survey of needs for alcohol and drug treatment resources for families in the current case load. The data are based on reports from forty area offices and social service sites in the state.

WESTERN MASSACHUSETTS

SUMMARY OF PITTSFIELD AREA OFFICE

It is estimated that the percentage of open cases, and also child abuse and neglect reports in this office that are drug/alcohol involved are 51% to 75%. There were no guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems. Training of social workers is needed to deal with the impact of substance abuse on family functioning. Mothers with young children are most in need of drug and alcohol treatment.

Drug/alcohol treatment resources were found to be adequate for fathers/other adult males and mothers with no child care needs; and inadequate for adolescents, mothers with young children, pregnant women/ pregnant teens, and battered women. The following resources for drug treatment are readily available: detox, out-patient treatment facilities, and self-help groups (NA, CA, ALANON, ALATEEN). Halfway houses are available but difficult to access. The following resources for drug treatment are not available: in-patient treatment facilities, community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens, and battered women.

The following resources for alcohol treatment are readily available: detoxification, out-patient treatment facilities, and self-help groups (AA, ALANON, ALATEEN). Halfway houses are available, but difficult to access. The following resources for alcohol treatment are not readily available: In-patient treatment facilities, community residential facilities for fathers/other male adults, adolescents, mothers/ no child care needs, mothers with young children, pregnant women/ pregnant teens, and battered women.

The most important treatment resource which is needed, but not available is community residential facilities for all ages. Treatment resources are, overall, readily available. Three readily available resources are detox programs, counseling, AA groups.

SUMMARY OF GREENFIELD/NORTHAMPTON AREA - NO DATA RECEIVED

SUMMARY OF HOLYOKE AREA OFFICE

It is estimated that the percentage of open cases, and also child abuse and neglect reports in this office that are drug/alcohol involved are 26% to 50%. The guides/directories available for referrals at the time of the survey was: the DPH Directory of Alcohol and Drug Treatment Programs. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. Training of social workers is needed in diagnosis, assessment, and development of service plans. Fathers/other male adults are most in need of treatment services. Drug/alcohol treatment resources were found to be inadequate for fathers/other male adults, adolescents, mothers with no child care needs, mothers with young children, pregnant women/pregnant teens, and battered women.

The following resources for drug treatment are readily available: ALANON(drug) and ALATEEN(drug). The following resources for drug treatment are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens, and battered women, and self-help groups (NA, CA, ALANON, drug, ALATEEN, drug).

Self-help groups (AA, ALANON, ALATEEN) are readily available resources for alcohol treatment. The following resources for alcohol treatment are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults, and adolescents.

The treatment resource that is most needed, but not available is for mothers with children. Treatment resources are, overall, available, but difficult to access. Three readily available resources are ALANON, ALATEEN, AA.

WESTFIELD SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases in this office that are drug/alcohol involved is 76% and more. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. At the time of the survey this office possessed a limited number of directories which were not current. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. Training of social workers is needed in dealing with resistant/hostile clients. Adolescents are most in need of drug/alcohol treatment. Drug/alcohol treatment resources are inadequate for the following groups: fathers/other male adults, adolescents, mothers with young children, pregnant women/pregnant teens, and battered women.

NA and ALATEEN(drug) are readily available resources for drug treatment. Community residential facilities for mothers with no child care needs for drug treatment are available, but difficult to access. The following resources for drug treatment

are not available: out-patient treatment facilities, halfway houses, and community residential facilities for adolescents and mothers with young children.

The following resources for alcohol treatment are readily available: detox, in-patient treatment facilities, AA, ALANON, and ALATEEN. Community residential facilities for mothers with no child care needs for alcohol treatment are available, but difficult to access. The following resources for alcohol treatment are not available: out-patient treatment facilities, halfway houses, and community residential facilities for adolescents and pregnant women/ pregnant teens.

The most important resource which is needed, but not available is community residential facilities with child care. Treatment resources for substance abuse are, overall, available but difficult to access. There is an excessive wait for adolescent Community Residential Services (up to six months). Three readily available resources are AA, ALANON, and ALATEEN.

SUMMARY OF SPRINGFIELD AREA OFFICE

It is estimated that the percentage of open cases, and also child abuse and neglect reports in this office that are drug/alcohol involved are 76% and more. The guides and directories were inadequate at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. Training of social workers is needed to deal with impact of substance abuse on family functioning. Mothers with young children are most in need of drug/alcohol treatment.

Drug/alcohol treatment resources were found to be inadequate for: fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens, and battered women.

NA and CA are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, community residential facilities for fathers/other male adults, and for mothers/no child care needs, ALANON (drug), ALATEEN (drug). Community residential facilities for adolescents, mothers with young children, pregnant women, pregnant teens, and battered women do not have resources available for drug treatment.

AA and ALANON are resources readily available for alcohol treatment. The following resources are available, but difficult to access: detox, in-patient treatment facilities, out-patient facilities, halfway houses, and community residential facilities for fathers/other male adults. Community residential facilities are not available resources for: adolescents, mothers/no child care needs, mothers with young children, and pregnant women/pregnant teens.

The most important resource which is needed, but not available is drug treatment for adults. Treatment resources are, overall, not available. The most available (shortest wait-list) resource is outpatient drug counseling for adults.

SUMMARY OF FITCHBURG AREA

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. The office did have in its possession guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is dealing with the impact of substance abuse on family functioning. Mothers with young children are most in need drug/alcohol services. Drug/alcohol treatment resources are adequate for fathers/other male adults, mothers/no child care needs, mothers with young children, and battered women. Drug/alcohol treatment resources are inadequate for adolescents and pregnant women/pregnant teens.

The following resources are readily available for drug treatment: detox, in-patient treatment facilities, out-patient treatment facilities, and ALANON. Resources that are available for drug treatment, but difficult to access are: halfway houses, community residential facilities for adolescents, NA, and ALATEEN(drug). Community residential facilities for pregnant women/pregnant teens are not available.

The following resources are readily available for alcohol treatment: detox, in-patient treatment facilities, out-patient treatment facilities, and ALANON(drug). Resources that are available for alcohol treatment, but difficult to access are: halfway houses, community residential facilities for adolescents, AA, and ALATEEN. Community residential facilities for pregnant women/pregnant teens are not available.

Treatment resources for substance abuse are, overall, available, but difficult to access. There is a major problem getting treatment for adults, resulting from lack of medical coverage and lack of client's motivation.

SUMMARY OF GARDNER SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases, and also child abuse and neglect reports in this office that are drug/alcohol involved is 26% to 50%. This office did have guides/directories in its possession at the time of the survey, such as the DPH publication, "Treatment programs serving adolescents with drinking problems." The staff is knowledgeable of substance abuse related problems, but would like further training. Training of social workers is needed to deal with the impact of substance abuse on family functioning. Mothers with young children are most in need of drug and alcohol treatment. Drug and alcohol treatment resources were found to be inadequate for all groups of consumers.

The only readily available resource for drug treatment is out-patient treatment facilities. The following resources for drug treatment are available, but difficult to access: Detox, in-patient treatment facilities, halfway houses, community residential facilities for all groups and NA. The following resources for drug treatment are not available: Cocaine Anon, ALANON and ALATEEN.

Detox and out-patient treatment facilities are the only readily available resources for alcohol treatment. The following resources for alcohol treatment are available, but difficult to access: in-patient treatment facilities, halfway houses, community residential facilities for all groups and AA, ALANON and ALATEEN.

The treatment resource which is most needed, but not available is self-help groups for drugs. Treatment resources are, overall, available, but difficult to access. Three readily available resources are: out-patient counseling (alcohol), self-help groups (for alcohol in urban areas only), and detox centers which are available, but are out of the area. There is a great need in the Gardner area for a drug testing site for both teens and adults, funded either through Medicaid or contract. Also there is a need for youth oriented NA and AA meetings.

SUMMARY OF SOUTH CENTRAL AREA OFFICE

It is estimated that the percentage of open cases in this office that are drug/alcohol involved is 51% to 75%. The estimated percentage of child abuse and neglect reports that are drug/alcohol involved is 26% to 50%. There were no guides/directories for referrals to drug treatment at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. Training of social workers is needed to deal with the impact of substance abuse on family functioning. Mothers with young children are most in need of drug and alcohol treatment. Drug/alcohol treatment resources were found to be inadequate for all groups of consumers.

There are no readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: out-patient treatment facilities, NA, ALANON(drug), and ALATEEN(drug). The following resources are not available for drug treatment: detox, in-patient treatment facilities, halfway houses, and community residential facilities for: fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. Out-patient treatment facilities are available for alcohol treatment, but difficult to access. The following resources are not available for alcohol treatment: detox, in-patient treatment facilities, halfway houses, and community residential facilities for: fathers/other male adult, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

The most needed resource which is not available is in-patient detox. Treatment resources for substance abuse are, overall, available, but difficult to access. Several readily available resources are: Tri-Link, Prospect House, AA, ALANON, and ALATEEN.

SUMMARY OF BLACKSTONE VALLEY SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that involve drugs/alcohol is 26% to 50%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is less than 25%. This office did have in its possession guides/directories for referrals for drug treatment. The staff is knowledgeable of substance abuse related problems. The type of training, specific to substance abuse related problems, most needed by social workers, is locating/utilizing treatment resources. Fathers/other male adults are most in need of drug/alcohol services. Drug/alcohol treatment resources are adequate for: fathers/other male adults, mothers/no child care needs, pregnant women/pregnant teens and battered women. Drug/alcohol treatment resources are inadequate for adolescents and mothers with young children.

There are no readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: NA, CA, ALANON and ALATEEN. The following

resources are not available for drug treatment: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following resources are not available for alcohol treatment: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF WORCESTER AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug alcohol involved is 26% to 50%. This office did have in its possession guides/directories for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is diagnosis, assessment and development of service plans. Fathers/other male adults are most in need of drug/alcohol services. Drug/alcohol treatment resources are adequate for fathers/other male adults and mothers/no child care needs. Drug/alcohol treatment resources are inadequate for adolescents, mothers with young children, pregnant women/pregnant teens, and battered women.

The following resources are readily available for drug treatment: detox, out-patient treatment facilities, NA, ALANON(drug), and ALATEEN(drug). Treatment resources that are available for drug treatment, but difficult to access are: in-patient treatment facilities, halfway houses, and community residential facilities for adolescents, mothers/no child care needs and mothers with young children. Community residential facilities for pregnant women/pregnant teens and battered women, and CA are not available resources for drug treatment.

The following resources are readily available for alcohol treatment: detox, out-patient treatment facilities, AA, ALANON, and ALATEEN. Resources that are available for alcohol treatment, but difficult to access are: in-patient treatment facilities, and community residential facilities for fathers/other male adults, adolescents, mothers with young children, and mothers/no child care needs. Community residential facilities for pregnant women/pregnant teens and battered women are not available resources for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

NORTHEAST MASSACHUSETTS

SUMMARY OF LOWELL AREA OFFICE

It is estimated that the percentage of open cases in this office that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 26% to 50%. This office did not possess any guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. Training of social workers is needed in identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol treatment. Drug/alcohol treatment resources are inadequate for all groups of consumers.

NA, ALANON(drug) and ALATEEN(drug) are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and community residential facilities for mothers/no child care needs and battered women. Halfway houses and community residential facilities for fathers/other male adult, adolescents, mothers with young children and pregnant women/pregnant teens are not available resources for drug treatment.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. The following resources for alcohol treatment are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for mothers with no child care needs and battered women. Community residential facilities for adolescents, mothers with young children and pregnant women/pregnant teens are not available as resources for alcohol treatment.

The most important resource which is needed, but not available is for adolescents. Treatment resources for substance abuse are, overall, available but difficult to access.

SUMMARY OF LAWRENCE AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that involve drugs/alcohol are 51% to 75%. The area office had no guides/directories for referrals for drug treatment in its possession at the time of the survey. The area staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The most important type of training specific to substance abusing families needed by social workers is identifying risk factors to the children. Pregnant women/pregnant teens are most in need of drug/alcohol treatment. Drug/alcohol treatment resources are inadequate for all groups of consumers.

NA, ALANON(drug), and ALATEEN(drug) are readily available resources for drug treatment. The following resources for drug treatment are available, but difficult to access: detox, out-patient treatment facilities, halfway houses and community residential services for adolescents. The following resources are not available for drug treatment: in-patient treatment facilities, and community residential services for fathers/ other male adults, mothers/no child care needs, mothers with young children, pregnant women and pregnant teens and battered women.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. Detox and out-patient treatment facilities are resources that are available for alcohol treatment, but difficult to obtain. The following resources are not available for alcohol treatment: in-patient treatment facilities, halfway houses and community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

The most important treatment resource which is needed, but not available is in-patient medical care. Treatment resources for substance abuse are, overall, not available. One readily available resource is self-help groups for any age.

SUMMARY OF HAVERHILL AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. The area office had guides/directories in its possession for referrals for drug treatment. The staff is knowledgeable of substance abuse related problems. The most important type of training, specific to substance abusing families, needed by social workers is diagnosis, assessment, and development of service plans. Mothers with young children are most in need of drug/alcohol treatment services. Drug/alcohol treatment resources are inadequate for all consumer groups in this area.

NA, ALANON(drug) and ALATEEN(drug) are readily available resources for drug treatment. Community residential services for adolescents are available, but difficult to access. The following resources are not available for drug treatment: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for fathers/other male adults, mothers with young children, pregnant women/pregnant teens and battered women.

AA, ALANON(drug), and ALATEEN(drug) are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for fathers/other male adult, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

The most needed treatment resource which is not available is for mothers with young children. Treatment resources for substance abuse are, overall, available, but difficult to obtain. Two readily available resources for substance abuse are TCA (counseling outreach) and Phoenix East (inpatient).

SUMMARY OF CAPE ANN SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases and supported child abuse and neglect reports involving drugs/alcohol are 51% to 75%. The office did have guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is knowledgeable about substance abuse related problems, but would like further training. The most important type of training, specific to substance abusing families, needed by social workers in your area is dealing with resistant/hostile clients. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

The following types of resources for drug treatment are available, but difficult to access: in-patient treatment facilities, out-patient facilities, NA, ALANON(drug), and ALATEEN(drug). The following resources are not available for drug treatment: detox, halfway houses, community residential facilities for all groups and Cocaine Anonymous.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. In-patient treatment facilities and out-patient treatment facilities are available treatment resources

for alcohol treatment, but difficult to access. The following resources are available for alcohol treatment, but difficult to access: detox, halfway houses and community residential facilities for all groups.

The most important resource which is needed, but not available is detox. Treatment resources for substance abuse are, overall, available, but difficult to access.

Former DANVERS/SALEM AREA OFFICE - no data received.

SUMMARY OF LYNN AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that involve drugs/alcohol is 76% and more. The office did not have guides/directories in its possession at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. The most important type of training, specific to substance abusing families, needed by social workers is how to deal with resistant/hostile clients. Mothers with young children are most in need of drug/alcohol service. Drug/alcohol resources are inadequate for all groups of consumers.

Self-help groups (NA, CA, ALANON and ALATEEN) are readily available resources for drug treatment. The following resources for drug treatment are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and community residential facilities for battered women. The following resources are not available for drug treatment: halfway houses and community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, and pregnant women/pregnant teens.

Self-help groups (AA, ALANON and ALATEEN) are readily available resources for alcohol treatment. Detox is available for alcohol treatment, but difficult to access.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF EASTERN MIDDLESEX AREA

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 76% and more. This office did have guides/ directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The most important type of training, specific to substance abusing families, needed by social workers is identifying risk factors to the children. Adolescents are most in need of drug/alcohol services. Drug/alcohol treatment resources are adequate for fathers/other male adults and mothers/no child care needs. Drug/alcohol treatment resources are inadequate for adolescents mothers with young children and pregnant women/pregnant teens.

NA and cocaine anonymous are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for adolescents, mothers/no child care needs and mothers with young children. Community residential facilities for pregnant women/pregnant teens are not available.

The following resources are readily available for alcohol treatment: detox, in-patient treatment facilities, out-patient treatment facilities, community residential facilities for mothers/no child care needs, AA, ALANON, and ALATEEN. Halfway houses are available for alcohol treatment, but difficult to access. Community residential facilities for adolescents, mothers with young children, pregnant women/pregnant teens and battered women are not available resources for alcohol treatment.

Community residential services for adolescents is the most needed treatment resource, but is not available.

SUMMARY OF TRI-CITY SITE (Now incorporated into E. MIDDLESEX AREA)

It is estimated that the percentage of open cases and also supported child abuse and neglect reports involving drugs/alcohol is 51% to 75%. The area office did have guides/directories in its possession for referrals for drug treatment at the time of the survey. The staff is knowledgeable about substance abuse related problems. The most important type of training, specific to substance abusing families, needed by social workers is diagnosis, assessment, and development of service plans. Pregnant women/pregnant teens are most in need of alcohol and drug treatment. Treatment resources are inadequate for all consumer groups.

Self-help groups (NA, CA, ALANON and ALATEEN) are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for pregnant women/pregnant teens and battered women. The following resources are not available for drug treatment: in-patient

treatment facilities and community residential facilities for adolescents, mothers/ no child care needs and mothers with young children.

AA and ALATEEN are readily available resources for alcohol treatment. The following are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient facilities, community residential facilities for mothers/no child care needs and mothers with young children, and ALANON. Resources not available for alcohol treatment are: in-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults, adolescents and pregnant women/pregnant teens.

Treatment resources are, overall, available, but difficult to access.

SUMMARY OF FRAMINGHAM AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports involving drugs/alcohol is 76% and more. This office did have guides/directories in its possession, although they needed updating. The staff is somewhat knowledgeable of substance abuse problems, but would like further training. The type of training, specific to substance abusing families, needed by social workers is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol services. Treatment resources are inadequate for all groups of consumers.

ALANON(drug), and ALATEEN(drug) are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, and halfway houses. Community residential facilities for all groups and Cocaine Anonymous are not available resources for drug treatment.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and halfway houses. Community residential facilities for all groups are not available for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access. Clients' denial of substance abuse problems is a significant problem in accessing services.

SUMMARY OF CONCORD AREA (Now part of FRAMINGHAM/MARLBOROUGH AREA)

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports involving drugs/alcohol is 26% to 50%. This office did have guides/directories in its possession for referrals for drug treatment. The staff is knowledgeable of substance abuse related problems. The most important type of training, specific to substance abusing families, needed by social workers is diagnosis, assessment, and development of service plans. Adolescents are most in need of drug/alcohol services. Drug/alcohol resources are adequate for the following groups: fathers/other male adult, mothers/no child care needs and battered women. Drug/alcohol resources are inadequate for mothers with young children and pregnant women/pregnant teens, as well as adolescents.

The following are readily available resources for drug treatment: out-patient treatment facilities, NA and ALATEEN(drug). Detox is an available resource for drug treatment, but it is difficult to access. The following resources are not available resources for drug treatment: in-patient treatment facilities, halfway houses, community residential facilities for all groups, Cocaine Anonymous, and ALATEEN.

The following are readily available resources for alcohol treatment: detox, out-patient treatment facilities, AA, ALANON, and ALATEEN. The following are not available resources for alcohol treatment: in-patient treatment facilities, halfway houses

and community residential facilities for fathers/other male adults, adolescents, mothers/no child care needs, mothers with young children, pregnant women/pregnant teens and battered women.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF MARLBOROUGH SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 26% to 50%. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. This office did have guides/directories for referrals for drug treatment in its possession at the time of the survey. The type of training, specific to substance abuse, most needed by social workers, is dealing with resistant/hostile clients. Fathers/other male adults are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

Out-patient treatment facilities and halfway houses are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: in-patient treatment facilities, NA, CA, ALANON and ALATEEN. Detox and community residential facilities for all groups are not available for drug treatment.

All types of resources are available, but difficult to access for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF CAMBRIDGE/SOMERVILLE AREA OFFICE

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 76% and more. This office did have in its possession guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable about substance abuse related problems, but would like further training. The type of training, specific to substance abuse, most needed by social workers is diagnosis, assessment and development of service plans. Mothers with young children are most in need of drug/alcohol services. Treatment resources are adequate for fathers/other male adults; and inadequate for adolescents, mothers with young children and pregnant women/pregnant teens.

The following resources are readily available for drug treatment: detox, out-patient treatment facilities, community residential services for fathers/other male adults, NA, CA, ALANON and ALATEEN. The following resources are available for drug treatment, but difficult to access: in-patient treatment facilities, halfway houses, and community residential facilities for adolescents, mothers/no child care needs, and mothers with young children. Community residential facilities for pregnant women/pregnant teens are not available resources for drug treatment.

The following resources are readily available for alcohol treatment: detox, out-patient treatment facilities, community residential facilities for fathers/other male adults and adolescents, AA, ALANON and ALATEEN. The following resources are available for alcohol treatment, but difficult to access: in-patient treatment facilities, halfway houses, and community residential facilities for mothers/no child care needs, mothers with young children and battered women. Community residential services for pregnant women/pregnant teens are not available.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF ARLINGTON SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases and also the percentage of supported child abuse and neglect reports, both involving drugs/alcohol, is 51% to 75%. The office did have guides/directories for referrals for drug treatment in its possession. The staff is somewhat knowledgeable of substance abuse problems, but would like further training. The type of training, specific to substance abusing families, needed by social workers is diagnosis, assessment and development of service plans. Battered women are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

Detox and in-patient treatment facilities are available resources for drug treatment, but are difficult to access. The following resources for drug treatment are not available: out-patient treatment facilities, halfway houses and community residential facilities for all groups.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and community residential services for adolescents. Halfway houses and community residential services for fathers/other male adults and pregnant women/teens are not available for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to obtain.

SUMMARY OF WALTHAM AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that involve drugs/alcohol is 51% to 75%. This office did have guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. Fathers/other male adults are most in need of drug/alcohol services, followed by mothers with young children.

All services are available for drug treatment, but difficult to access.

AA is a readily available resource for alcohol treatment. All other resources for alcohol treatment are available, but difficult to access.

Detox for adolescents is a resource which is most needed, but not available. Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF NEWTON AREA (Now incorporated into WALTHAM AREA)

It is estimated that the percentage of open cases and supported 51A reports that are drug/alcohol involved is 51% to 75%. This office did have guides/directories in its possession for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is dealing with the impact of substance abuse on families. Drug/alcohol treatment resources are adequate for father/other male adults and mothers/no child care needs; and inadequate for adolescents and mothers with young children.

Out-patient treatment facilities and NA are readily available resources for drug treatment. Detox and in-patient treatment facilities are available for drug treatment, but difficult to access. The following resources are not available for drug treatment: halfway houses, community residential facilities for all groups, Cocaine Anonymous, ALANON and ALATEEN.

The following resources are readily available for alcohol treatment: detox, in-patient treatment facilities, out-patient treatment facilities, AA, ALANON and ALATEEN. Community residential facilities for adolescents, mothers/no child care needs and mothers with young children are available for alcohol treatment, but difficult to access. Resources that are not available for alcohol treatment are: halfway houses and community residential facilities for fathers/other male adults, pregnant women/pregnant teens and battered women.

Treatment resources for substance abuse are, overall, available, but difficult to obtain. Training that involves combining substance abuse with child development issues would be useful for all staff.

SOUTHEAST MASSACHUSETTS

SUMMARY OF QUINCY AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol related is 76% and more. This office did have guides/directories for referrals of drug treatment in its possession. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is diagnosis, assessment and development of service plans. Mothers with young children are most in need of drug/alcohol services. Treatment resources for all groups of consumers are inadequate.

The following treatment resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, NA, ALANON(drug) and ALATEEN(drug). The following resources are not available for drug treatment: halfway houses, community residential facilities for all groups and CA.

AA and ALANON are readily available resources for alcohol treatment. Out-patient treatment facilities and ALATEEN are available for alcohol treatment, but difficult to access. The following treatment resources are not available for alcohol treatment: detox, in-patient treatment facilities, halfway houses and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, not available. There is a two month wait list, even for outpatient alcohol and drug counseling.

SUMMARY OF WEYMOUTH SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that are drug/alcohol related is 76% and more. The percentage of supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. The office did not have guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is identifying risk factors to the children. Fathers/other male adults are most in need of drug/alcohol services. Treatment resources are inadequate for all groups of consumers.

Resources that are readily available for drug treatment are: NA, CA, ALANON(drug) and ALATEEN(drug). Detox and in-patient treatment resources are resources that are available, but difficult to obtain. The following treatment resources are not available for drug treatment: out-patient treatment facilities, halfway houses and community residential facilities for all groups.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. Alcohol treatment resources that are available, but difficult to obtain are: detox, in-patient treatment facilities and out-patient treatment facilities. Halfway houses

and community residential facilities for all groups are not available for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF ATTLEBORO AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. The office did have guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers, is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers except for fathers/other male adults.

The following resources are readily available for drug treatment: community residential facilities for battered women, NA, ALANON and ALATEEN. Drug treatment resources that are available, but difficult to obtain are: detox, in-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults and adolescents. The following treatment facilities are not available: out-patient treatment facilities, community residential facilities for mothers/no child care needs, mothers with young children and pregnant women/ pregnant teens, and Cocaine Anonymous.

The following resources for alcohol treatment are readily available: detox, community residential facilities for battered women, AA, ALANON and ALATEEN. The following resources for alcohol treatment are available, but difficult to obtain: in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adult, adolescents and mothers/no child care needs.

Treatment resources for substance abuse are, overall, not available. There are few halfway houses or detox facilities for women.

SUMMARY OF NORWOOD SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that involve drugs/alcohol is 26% to 50%. The estimated percentage of supported child abuse and neglect reports that involve drugs/alcohol is less than 25%. This office had no guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers, is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol services. Treatment resources are inadequate for all groups of consumers.

The following treatment resources for drug treatment are readily available: detox, NA, CA, ALANON(drug) and ALATEEN(drug). The following resources are available for drug treatment, but difficult to access. In-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential services for all groups.

The following resources are readily available for alcohol treatment: detox, AA, ALANON and ALATEEN. In-patient treatment facilities and out-patient treatment facilities are available for alcohol treatment, but difficult to access. Halfway houses and community residential facilities for all groups are not available for alcohol treatment.

Treatment resources are, overall, available, but difficult to access.

SUMMARY OF TAUNTON SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol related is 76% and more. This office had no guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers, is identifying risk factors to the children. Pregnant women/pregnant teens are most in need of drug/alcohol services. Treatment resources for fathers/other male adults and mothers with young children are adequate; and treatment resources for adolescents, pregnant women/pregnant teens and battered women are inadequate.

NA and ALANON(drug) are readily available resources for drug treatment. Out-patient treatment facilities and halfway houses are available resources for drug treatment, but difficult to access. The following treatment resources for drug treatment are not available: detox, in-patient treatment facilities, community residential facilities for all groups, Cocaine Anonymous, and ALATEEN.

AA and ALANON are readily available resources for alcohol treatment. ALATEEN is available for alcohol treatment, but difficult to access. The following resources are not available for alcohol treatment: detox, in-patient treatment facilities, out-patient treatment facilities and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, not available. The greatest needs are community residential services for adolescents and pregnant women/pregnant teens, and outpatient services for all groups. Programs that are present in the area usually refuse to take Medicaid.

SUMMARY OF BROCKTON AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that involve drugs/alcohol is 51% to 75%. The office did have in its possession guides/directories for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol service. Drug/alcohol treatment resources are inadequate for all groups.

Resources that are readily available for drug treatment are: detox, NA, ALANON(drug), and ALATEEN(drug). The following resources are available for drug treatment, but difficult to access: in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential services for fathers/other male adults, mothers/no child care needs and battered women. Community residential facilities for adolescents, mothers with young children, and pregnant women/pregnant teens are not available for drug treatment.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults, mothers/no child care needs and battered women. Community residential services for adolescents, mothers with young children, and pregnant women/pregnant teens are unavailable.

Treatment resources for substance abuse are, overall, available, but difficult to obtain. While resources exist, waiting lists and other factors that impact on securing services for substance abusing consumers create exceptionally long waiting periods.

SUMMARY OF FALL RIVER AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. This office did have guides/directories for referrals for drug treatment in its possession at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is identifying risk factors to children. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

Resources that are readily available for drug treatment are out-patient treatment facilities and NA. Detox and halfway houses are available for drug treatment, but difficult to access. The following resources for drug treatment are not available: in-patient treatment facilities, community residential facilities for all groups, ALANON(drug) and ALATEEN(drug).

Readily available resources for alcohol treatment are out-patient treatment facilities, AA and ALANON. Detox, halfway houses and ALATEEN are available for alcohol treatment, but difficult to access. Resources that are not available for alcohol treatment are in-patient treatment facilities and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, available but difficult to obtain.

SUMMARY OF NEW BEDFORD AREA OFFICE

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug alcohol involved is 51% to 75%. The staff is knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers, is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

Drug treatment resources that are readily available are NA, CA, ALANON, and ALATEEN. Detox and out-patient treatment facilities are available for drug treatment, but difficult to access. The following drug treatment resources are not available: in-patient treatment facilities, halfway houses and community residential facilities for all groups.

AA, ALANON, and ALATEEN are readily available treatment resources for alcohol treatment. Resources that are available for alcohol treatment, but difficult to access are: detox, out-patient treatment facilities and halfway houses. In-patient treatment facilities and community residential facilities for all groups are not available resources for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF CAPE AND ISLANDS AREA

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. This office did have in its possession guides/directories for referrals for drug treatment at the time of the survey. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The most important type of training, specific to substance abuse related problems, needed by social workers is diagnosis, assessment, and development of service plans. Fathers/other male adults are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

The following resources are available for drug treatment, but difficult to access: NA, CA, ALANON, and ALATEEN. The following resources are not available for drug treatment: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for all groups.

Detox is a readily available resource for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: in-patient treatment facilities, out-patient treatment facilities, AA, ALANON, and ALATEEN. Halfway houses and community residential facilities for all groups are not available for alcohol treatment.

Treatment resources for substance abuse are, overall, not available. The Area reports having to go out of state for treatment resources.

SUMMARY OF PLYMOUTH SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. The office did have in its possession guides/directories for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse problems, but would like further training. The type of training most needed by social workers is diagnosis, assessment, and development of service plans. Mothers with young children are most in need of drug/alcohol services. Treatment resources are adequate for fathers/other male adults, mothers/no child care needs and battered women; and inadequate for adolescents and mothers with young children.

NA, ALANON and ALATEEN are readily available resources for drug treatment. Resources that are available, but difficult to access are: detox, in-patient treatment facilities, out-patient treatment facilities, and halfway houses. Community residential facilities for all groups are not available for drug treatment.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. The following resources are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, and halfway houses. Community residential facilities for all groups are not available resources for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

BOSTON/BROOKLINE REGION

SUMMARY OF MORTON STREET AREA

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 76% and more. This office did have guides/directories in its possession. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is identifying risk factors to the children. Adolescent are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

NA, ALANON, and ALATEEN are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for fathers/other male adults and battered women. Community residential facilities for adolescents, mothers with young children and pregnant women/pregnant teens are not available.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient facilities, halfway houses and community residential facilities for mothers with no child care needs. Community residential facilities for fathers/other male adults, adolescents, mothers with young children, pregnant women/pregnant teens and battered women are not available for alcohol treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access. A funding mechanism for clients, without any third party insurance, is needed for urine testing.

DIMOCK STREET AREA (See BOSTON UNIVERSITY AREA, below.)

SUMMARY OF ALLSTON SOCIAL SERVICE CENTER

It is estimated that the percentage of open cases that are drug/alcohol involved is 76% and more. The estimated percentage of supported child abuse and neglect reports involving drugs/alcohol is 51% to 75%. This office did have guides/ directories in its possession for referrals for drug treatment at the time of the survey. The staff is knowledgeable of substance abuse related problems. The type of training, specific to substance abusing families, most needed by social workers is identifying risk factors to the children. Mothers with young children are most in need of drug/alcohol service.

CA, ALANON, and ALATEEN are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for all groups.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following resources are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses, and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF BOSTON UNIVERSITY AREA OFFICE (Currently split between the DIMOCK STREET and SOLOMON CARTER FULLER MENTAL HEALTH CENTER AREAS.)

It is estimated that the percentage of open cases that are drug/alcohol involved is 51% to 75%. The estimated percentage of supported child abuse and neglect reports that are drug/alcohol involved is 76% and more. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is dealing with the impact of substance abuse on family functioning.

NA and ALATEEN(drug) are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, halfway houses and community residential facilities for fathers/other male adults, mothers/ no child care needs and battered women.

AA, ALANON and ALATEEN are readily available resources for alcohol treatment. The following resources for alcohol treatment are available, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities, and community residential facilities for fathers/others male adults, mothers with young children and battered women. Community residential facilities for adolescents, mothers with no child care needs and pregnant women/pregnant teens are not available.

Treatment resources for substance abuse are, overall, available, but difficult to access. There is an especially high need for substance abuse treatment programs that provide residential services for mothers and children who are housed together.

SUMMARY OF FIELDS CORNER AREA

It is estimated that the percentage of open cases and supported child abuse and neglect reports that are drug/alcohol involved is 51% to 75%. This office did have in its possession guides/directories for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse related problems, but would like more training. The type of training, specific to substance abusing families, most needed by social workers, is diagnosis, assessment, and development of service plans. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

NA, CA, ALANON, and ALATEEN are readily available resources for drug treatment. The following resources are available for drug treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and community residential facilities for fathers/other male adults. Community residential facilities for adolescents, mothers with young children, pregnant women/pregnant teens, and battered women are not available for drug treatment.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following are available for alcohol treatment, but difficult to access: detox, in-patient treatment facilities, out-patient treatment facilities and community residential facilities for fathers/other male adults. Halfway houses and community residential facilities for all other groups, besides fathers/other male adults, are not available for treatment.

Treatment resources for substance abuse are, overall, available, but difficult to access.

SUMMARY OF HARBOR AREA OFFICE (Including Chelsea and Charlestown)

It is estimated that the percentage of open cases and supported child abuse and neglect reports is 76% and more. This office did have guides/directories in its possession for referrals for drug treatment. The staff is somewhat knowledgeable of substance abuse related problems, but would like further training. The type of training, specific to substance abusing families, most needed by social workers is the impact of substance abuse on family functioning. Mothers with young children are most in need of drug/alcohol services. Drug/alcohol treatment resources are inadequate for all groups of consumers.

ALANON and ALATEEN are readily available resources for drug treatment. Halfway houses and community residential facilities for fathers/other male adults are available, but difficult to access. The following resources are not available for drug treatment: detox, in-patient treatment facilities, out-patient facilities, community residential facilities for all groups with the exception of fathers/other male adults, NA, and Cocaine Anonymous.

AA, ALANON, and ALATEEN are readily available resources for alcohol treatment. The following are available for alcohol treatment, but difficult to access: detox, out-patient treatment facilities, and halfway houses. Alcohol treatment resources that are not available for treatment are in-patient treatment facilities and community residential facilities for all groups.

Treatment resources for substance abuse are, overall, available, but difficult to access. This Area reports an alarming increase over the past year in child abuse and neglect reports associated with the use of all forms of cocaine. In addition, Chelsea has recently been added to the Harbor Area and Chelsea police are filing child abuse reports in any drug-related arrest where there are children in the home. This can be expected to create additional stresses on the service system even further, by increasing the proportion of protective cases associated with drug use.

APPENDIX B

AREA SURVEY INSTRUMENT



Marie A. Matava
Commissioner

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Social Services

150 Causeway Street
Boston, Mass. 02114

Tel: (617) 727-0900

May 4, 1989

To: Area Directors

From: ~~James L. Bell~~
Assistant Commissioner for Professional Services

Through: Janet W. Eustis
Deputy Commissioner

Re: Assessment of the Need and Availability of
Drug and Alcohol Treatment Services.

The Research, Evaluation and Planning Unit in the Office for Professional Services is in the process of assessing the need for services to families with substance abuse problems. Findings from a study in the Boston Region have indicated that DSS social workers are working with a substantial number of families having substance abuse problems. [A copy of the report of that study is enclosed. A similar statewide data collection effort will be done this summer.] Along with these approaches to ascertaining the size of the problem, we are also directing our attention to the area perspective on the availability of substance abuse treatment services for families in our caseload.

Attached you will find a questionnaire we plan to use to clarify the need both for treatment resources and the social worker supports necessary for acquiring them for DSS families with substance abuse problems, especially where these problems are associated with child maltreatment and other domestic violence.

Please answer the questions in the survey as accurately as possible. It would be especially helpful if the survey was completed by the area management team, in consultation with supervisors and social workers. The questionnaire is brief and because the information is primarily qualitative and comparative, it should not take long to complete. While we are not asking you to spend time compiling quantitative data, we would appreciate your forwarding any quantitative information you have already collected that might further illuminate the situation in your area -

NEEDS ASSESSMENT
SUBSTANCE ABUSE TREATMENT SERVICES

for example, waiting periods for residential drug treatment services or the percentage of referrals that were completed or rejected for alcohol abusing adolescents. The REP Unit will be preparing a summary report on the basis of the surveys you return; they will attempt to provide area-based summaries as well as regional and statewide overviews of the information received. It is therefore essential that all areas complete and return their surveys.

Please return your completed survey before 6/26/89 to:

Research, Evaluation, and Planning Unit
Department of Social Services
150 Causeway Street
Boston, MA 02114

Attn. Magueye Seck

If you have any questions, please call Julia Herskowitz at 727-0900, Ext. 261.

Thank you in advance for your cooperation.

SUBSTANCE ABUSE NEEDS ASSESSMENT
AREA SURVEY

REGION: _____ AREA _____ DATE COMPLETED: ____/____/____

1. a) Do you estimate the percentage of open cases in your office that are drug/alcohol involved as:
(Please check only one range)

_____ Less than 25%
_____ 26 to 50%
_____ 51 to 75%
_____ 76% and more

- b) Do you estimate the percentage of supported 51A reports that are drug/alcohol involved as:

_____ Less than 25%
_____ 26 to 50%
_____ 51 to 75%
_____ 76% and more

2. Does the area office have in its possession guides/directories for referrals for drug treatment? (check one)

_____ Yes
_____ No

If Yes, please give the following information:

Source

Date of publication

3. Please describe your area staff in terms of how much they know about substance abuse related problems. (check one)

_____ Very knowledgeable
_____ Knowledgeable
_____ Somewhat knowledgeable, but would like further training

4. Please rate (1 through 6) the types of training, specific to substance abusing families, needed by social workers in your area. (1 being the most important).

_____ Diagnosis, assessment, and development of service plans
_____ Locating/utilizing treatment resources
_____ Identifying risk factors to the children
_____ Dealing with resistant/hostile clients
_____ Impact of substance abuse on family functioning
_____ Cultural issues

5. For the families in your area caseload, how would you describe the needs of the following groups of consumers for drug/alcohol services? Please rank the following groups of consumers by their need for alcohol and drug treatment services in order from 1 to 7, (1 being the most in need).

_____ Fathers/Other male adult
 _____ Adolescents
 _____ Mothers/no child care needs
 _____ Mothers with young children
 _____ Pregnant women/pregnant teens
 _____ Battered women
 _____ Others (please specify: _____)

6. Describe the adequacy of drug/alcohol treatment resources for the following groups of consumers in your area caseload?

	ADEQ	INADEQ	UNKNOWN
Fathers/other male adult.....	_____	_____	_____
Adolescents.....	_____	_____	_____
Mothers/no child care needs.....	_____	_____	_____
Mothers with young children.....	_____	_____	_____
Pregnant women/pregnant teens...	_____	_____	_____
Battered women.....	_____	_____	_____
Others (specify).....	_____	_____	_____

7. How would you describe the availability of the following types of resources for DRUG TREATMENT in your area?
 (RA = READILY AVAILABLE) (A/DO = AVAILABLE BUT DIFFICULT TO OBTAIN) (NA = NOT AVAILABLE) (NS = NOT SURE)

	RA	A/DO	NA	NS
Detoxification	_____	_____	_____	_____
In-patient treatment facilities...	_____	_____	_____	_____
Out-patient treatment facilities..	_____	_____	_____	_____
Halfway houses	_____	_____	_____	_____
Community residential facilities..	_____	_____	_____	_____
(Fathers/other male adult).....	_____	_____	_____	_____
(Adolescents)	_____	_____	_____	_____
(Mothers/no child care needs)...	_____	_____	_____	_____
(Mothers with young children)...	_____	_____	_____	_____
(Pregnant women/pregnant teens)..	_____	_____	_____	_____
(Battered women)	_____	_____	_____	_____
Self-help groups				
(Narcotics Anon)	_____	_____	_____	_____
(Cocaine Anon)	_____	_____	_____	_____
(ALANON, drug)	_____	_____	_____	_____
(ALATEEN, drug)	_____	_____	_____	_____

8. How would you describe the availability of the following types of resources for ALCOHOL TREATMENT in your area?
 (RA = READILY AVAILABLE) (A/DO = AVAILABLE BUT DIFFICULT TO OBTAIN) (NA = NOT AVAILABLE) (NS = NOT SURE)

	RA	A/DO	NA	NS
Detoxification	___	___	___	___
In-patient treatment facilities...	___	___	___	___
Out-patient treatment facilities..	___	___	___	___
Halfway houses	___	___	___	___
Community residential facilities				
(Fathers/other male adult)	___	___	___	___
(Adolescents)	___	___	___	___
(Mothers/no child care needs)...	___	___	___	___
(Mothers with young children)...	___	___	___	___
(Pregnant women/pregnant teens)..	___	___	___	___
(Battered women)	___	___	___	___
Self-help groups				
(Alcohol Anon.)	___	___	___	___
(ALANON)	___	___	___	___
(ALATEEN)	___	___	___	___

9. Of the above treatment resources which are needed but not available in your area, please list in order of importance:
 (1= most needed)

1 _____
 2 _____
 3 _____

10. For your area, how would you rate the ability of the following systems in providing help/services to children affected by substance abuse and its related family violence?

	EXC	VERY GOOD	GOOD	FAIR	POOR
Extended Family ..	___	___	___	___	___
Mental Health	___	___	___	___	___
Health Care	___	___	___	___	___
Friends	___	___	___	___	___
Employers	___	___	___	___	___
School	___	___	___	___	___
Courts	___	___	___	___	___
Police	___	___	___	___	___
Cultur/Relig.Inst.	___	___	___	___	___
Private Soc.Serv.	___	___	___	___	___

11. In terms of treatment resources for substance abuse that are present in your area, how would you describe the overall availability of these resources for DSS social worker referrals? (Please check one).

- ☐ Readily available
☐ Available but difficult to obtain
☐ Not available

12. List readily available resources, if any, by type and client group served:

TYPE OF RESOURCE:

CLIENT GROUP SERVED:

13. If you have any quantitative data on waiting time, referrals made and/or rejected, or other figures that would help document the severity of need in your area, please attach.

If you have comments you wish to add, please use this space.
THANK YOU.

REP UNIT: MAY, 1988

Completed by:



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HUMAN SERVICES
DEPARTMENT OF SOCIAL SERVICES

MARIE A. MATAVA
COMMISSIONER

Draft

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May 24, 1990

To: Gerald W. Robinson, Assistant Commissioner
Office for Professional Services

From: Frances I. Wheat, Evaluation Specialist
Research, Evaluation and Planning Unit

Re: Preliminary Findings - Mental Health Needs Assessment

On October, 1989, a mental health needs assessment survey was sent to all DSS Area Directors and Social Service Center Directors, and a selected number of Partnership Agency Directors asking them to consult with their social workers, area program managers, Department of Mental Health (DMH) prescreening team, and community leaders to obtain the most accurate information available on our clients. Follow-up was initiated in December, subsequently resulting in the return of thirty-six surveys, representing twenty DSS area offices, nine DSS Social Service Centers, and six Partnership Agencies. The surveys were analyzed on a statewide basis and preliminary findings summarized in the next few pages. The survey results, together with the recommendations from the Professional Advisory Sub-committee on Access to Mental Health Services, and summary findings from a report on "Problems and Issues in Meeting the Mental Health Needs of DSS Multi-Cultural Consumers," recently completed by a DSS intern, provide future policy and programmatic directions for the Department.

1. Profile of Children With Mental Health Needs. Five thousand and fifty-seven DSS children were determined by 30 respondents to be in need of mental health services from DMH or other agencies in fiscal year 1989. Twenty-seven percent (1366) of these were referred to the DMH prescreening teams. Nine percent (452) were hospitalized, but not referred to the teams. Most of the 452 children were referred to hospitals by non-DSS staff (the child, the child's physician, therapist, and/or parents) and/or had

private insurance. Others were hospitalized for diagnostic evaluation or determined not to be at risk - not a life threatening situation, child's behavior is not severe, a need for a medication probe is identified. Less frequently mentioned were hospitalizations through court committal or referral, for children already in the hospitals and seeking DSS services, or for children returning to the same hospital (second admission). Respondents encountered some obstacles with DMH, e.g., child psychologist not available, only active suicides accepted by the Team, or requirements for completed referral packages for screening delays the process.

2. Behavioral Characteristics of Children Using DMH or Alternative Mental Health Resources. The survey participants were asked to describe the behavioral and any other distinguishing characteristics of children able to obtain mental health services through the DMH prescreening teams, and to share how they differed from those screened out by or not referred to the teams.

Committable Children. The most (28 times) frequently described behaviors for this group of children are suicidal gestures and active suicides - overdosing on medications or pills, slicing wrists, carving on arms, and wishing to die and the child will state the same to the DMH psychiatrist. Described next were (active) psychotic behaviors such as hearing voices, verbalizing, hallucinating, personality disorders, and catatonic behavior, followed by (active) homicidal ideation or gestures. Also frequently mentioned by respondents were significant behavioral problems, for example, children physically and/or sexually assaultive, violent, abusive, and aggressive.

"Would Benefit" Children. A behavior disorder diagnosis best describes this group of children and youth. Mentioned most (14 times) frequently, respondents characterized behavior disorders as conduct disorder, severe acting out, uncontrollable behavior, adolescent adjustment reaction, and oppositional behavior. Depression was mentioned eleven times and included situational grief due to the loss of a friend and withdrawn behavior. Suicidal ideation and gestures, and substance abuse by these children were both mentioned ten times.

Children Screened Out by the Teams. These are children who did not meet the DMH criteria for hospitalization, i.e., they were not "committable" nor were they children who "would benefit from hospitalization." The behavioral pattern for this group of children was more difficult to identify, since respondents named numerous behaviors. Emphasis was placed on behavior disorders (10 times) with reference for the first time to attention-seeking behaviors and behaviors which make placements difficult and some

times impossible. Active suicides, suicidal gestures, contemplation and threats were mentioned next (6 times). Substance abusers (3), truants and runaways - multiple occurrences (4), depressed children sometimes responsive to outpatient therapy (4), and children with dysfunctional families exhibiting substance abuse (3) were also highlighted. Other behaviors, such as intense anger, low self esteem, and underachievement were mentioned infrequently.

Children Not Referred. Behavioral disorders (and a history of) characterizes these children (14 times). Behavioral terms, such as delinquent, unstable, attention-seeking, acting out, and aggressive were used by the respondents. Substance abusers and truants, runaways, and stubborn children (CHINS) were highlighted (7 and 6 times, respectively). The respondents stated (5 times) that these children had the same behaviors as the children referred to, but screened out by the DMH teams.

3. Length of Wait to Screen in a Child Once the Team is Called. Of the 31 respondents, over two-thirds (68%) said it took no more than ten hours to screen in a child. The rest (32%) of the respondents gave a wide range of answers to this question. Some respondents remarked that the wait time is correlated with whether the case is an emergency or not, in a rural or urban area, involves a young child and age appropriate psychologists are not available, and the amount of time it takes to meet the requirements for screen in.

4. Length of Wait for Placement or Program Entry Once Screened In. Table 1 indicates that the majority (80%) of "committable" children wait for placement or entry no more than two days. For children who "would benefit," the wait is longer.

5. Do Social Workers Choose not to put Children on Wait Lists? More than two-thirds (67%) of the 36 respondents indicated that social workers put children on wait-lists for mental health resources, even though the length of wait is known to be too long. Twenty-five percent (9 respondents) did not wait list children. Eight percent did not respond to this survey question.

Participants in the survey were asked to identify mental health resources with chronically long wait lists. Most frequently mentioned were residential care facilities, community mental health centers, substance abuse programs, outpatient programs for the sexually abused, inpatient evaluations for non-committables, and counseling/intensive treatment programs.

6. Resources Secured for Children Screened Out by and Not Referred to the Teams. Survey participants were asked to list the resources provided to children who were referred, but screened out by the DMH prescreening team and for children DSS and PAS agency staff did not refer.

A review of Table 2 indicates that DSS and PAS agency staff used emergency shelters most frequently for both groups of children. Other resources used, although to a different degree for screened out versus non-referred children, include home (with parents or relatives), sometimes with DMH respite care or out-patient counseling/therapy as a support; foster care; community residential services; private hospitals; and specialized foster care. Therapeutic services (counseling) were frequently used for children not referred (7), but infrequently for those who were screened out (1).

7. Appropriateness of Resources Secured for Children Screened In, Screened Out, and Not Referred to the Team. Almost two-thirds of the respondents stated that resources secured for children screened in by the DMH Teams were appropriate to their mental health needs. In comparison, resources secured for children screened out by the Team or not referred were not as appropriate; only 31% were satisfied with the resources (See Table 3.)

For children screened in by the teams, those who said that resources were inappropriate or had mixed feelings, referenced these themes: a. the need for more resources due to the unavailability of hospital beds in general, but especially the need for immediate beds to facilitate inpatient evaluations; b. the need for more hospital diversion programs for "would benefit" children such as residential care geared to serving children with mental health needs, "specials" to provide 24 hour care in any non-DMH setting, and placements to accomodate incidental fire setting behavior; c. the need for post-hospitalization services (there is often no long term resource for the child), increased quality of diagnostic evaluations provided to children in hospitals, and increased availability of psychiatrists who will prescribe psychotropic medication to a child on an out-patient basis.

Children Screened Out or Not Referred. When children were screened out by the teams or not referred, survey participants, who believed that the resources provided were inappropriate or had mixed feelings, made the following points: a. regular foster care is used inappropriately for children really in need of in-patient care; b. children are often wait listed, particularly those at home needing out-patient therapy; c. Out-patient resources are inappropriate for unstable adolescents who have an attendance problem; d. CRS programs with a mental health component are needed, as well as DMH services for younger children,

to prevent later placement in CRS programs; e. alternative program models are needed for CRS children, who are not yet ready for foster care; f. emergency shelters have few, if any, therapeutic components; and f. there is a need for more specialized therapists.

8. Services Used and Needed to Meet Mental Health Needs. As depicted in Figure 1, thirty-six respondents most frequently mentioned needing substance abuse treatment programs, tracking, day treatment for adolescents, staff secure treatment facilities, parent aides, specialized foster care, diagnosis and assessment services for children five to twelve year old, and post-hospitalization services.

9. DSS Diagnostic and Assessment Centers. Five hundred and seventy-three adolescents were referred by 34 respondents to the DSS diagnostic and assessment centers in fiscal year 1989. One-third (191) of those referred were placed that year. Ninety-five percent (182) of the placement population waited for that placement two weeks or more. Eighty percent (152) of the placement population were discharged by the centers to their recommended aftercare placements.

Adolescents , who were not discharged to their recommended aftercare placements: did not complete the program; exhibited behavior unacceptable to the facility; were moved to an interim placement while awaiting a community residential slot or were unable to find a long-term residential placement at all; were found not to be in need of a placement; the area social worker disagreed with the center staffs' recommendation; or insufficient time between the placement recommendation and discharge was provided to the social worker to secure other, appropriate arrangements.

Respondents were asked to share their general observations about diagnostic and assessment services. In a positive light, many of the respondents remarked about the center's success at stabilizing youth, especially those with chronic emotional and behavioral problems exacerbated by multiple placements and disruptions. On the other hand, respondents who made less positive comments about the diagnostic and assessment centers emphasized a long waiting list for placement, unavailability of the services (no slots, even for some court ordered children), and after care resources that were lacking or unidentified by center staff.

10. Populations in Need of Mental Health Resources. As seen in Figure 2, the respondents identified a critical need for services to substance abusers who are emotionally disturbed, older adolescents, and juvenile offenders. A high need was recorded for most of the remaining sub-populations shown on the graph, with priority given to mentally retarded children with emotional disturbances (5-18), non-English speaking clients, and minorities such as Hispanics, South East Asians, Cape Verdians/Portuguese, and Blacks. Infants and toddlers was the only sub-population to receive a moderate need score.

11. Accessability of Mental Health Resources for Children Funded Through Different Payment Mechanisms. Figure 3 displays seven sources of funding used for children who need to access mental health resources. Respondents were asked to determine whether individual funding mechanisms facilitated access to these services, was problematic, or not an issue.

Out of the 252 possible responses to this question, 44% of the respondents rated all funding sources problematic, 27% indicated they were not an issue, 14% felt they facilitated access, and 15% did not respond.

Viewed as the most (58%) problematic, in reference to funding source, were children involved with the Department of Mental Retardation (DMR), followed equally by Medicaid eligibles and children solely funded by DSS (50%) and then by the Department of Youth Services (DYS - 45%).

Half (18) of the respondents indicated that private, third party insurance facilitates children's access to mental health resources: no other funding mechanism received such a favorable rating. The respondents noted, however, that (ease of) access was dependent on the identity of the insurance carrier. An HMO, for example, was viewed as problematic, because their policies can be extremely restrictive regarding what mental health services are covered. More success in hospitalization was obtained when families carried Blue Cross/Blue Shield, but even with these insurers, the amount of client contact is limited and as one respondent stated, "children are quickly 'cured' when the insurance runs out."

12. Relationship with the Department of Mental Health. Nearly three-quarters (72%) of the respondents were satisfied with their relationship with the DMH prescreening teams. (See Table 4.) At the area level, said one respondent, the "DSS-DMH relationship often very simply depends on the persons involved." When their attitude and approach is cooperative and there is mutual trust and respect, things work well even though there may still be resource issues. Other offices mentioned that they find regular interagency meetings a help in overcoming problems and facilitating communication and delivery of services to difficult cases.

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The majority (16) of satisfied office staff thought their relationship with DMH affected their ability to access services. Although respondents generally felt they had a professional, positive working relationship with the team, there were problem areas. "The non-committable, 'would benefit from hospitalization' category (of children) seems to present the greatest area of controversy," said one survey participant. "This category is either not addressed by some teams or if addressed, the decision in some cases is driven by availability of resources..." Furthermore, "There is no appeal mechanism when DMH disagrees with hospitalization other than having the client exercise appeal rights through the Department of Public Welfare."

13. Impact of the DSS/DMH Interagency Agreement. Office staff were asked what impact, if any, the "DSS/DMH Interagency Agreement on Crisis Intervention and Psychiatric Hospitalization" had in their area. (See the attached Agreement.) At least eleven respondents stated that the Agreement clarified interagency roles and responsibilities. Eight others indicated there was no impact, referencing no increase or decrease in referrals or no change in their relationship with DMH. Four participants said that DMH plays little or no role in servicing non-committable children, indicating that "at-risk kids are totally DSS' responsibility," that DSS has to do more work now because they have to call the hospitals, and that DMH personnel ask DSS what resources they have so they can keep kids out of the hospitals.

14. Are Children Hospitalized Too Long? Significantly, 78% of the respondents stated that children do not remain too long. (See Figure 4.) In fact, respondents commented that some children do not stay long enough as seen in the following remarks.

Respondents most frequently mentioned that children are automatically discharged when their insurance runs out (termed early release). In addition, sometimes they are not stabilized, the discharge plans not realistic, and the aftercare, usually residential, is inappropriate. Survey participants also emphasized that long-term treatment for some children was clearly needed to assure any kind of success in a community setting and felt that children were being discharged too early. Several respondents remarked that hospitalized youth with behavior problems are discharged precipitously because the ward staff find them difficult. Other respondents indicated that children may need to stay longer when undergoing symptom management through medication to assure generalized stability before discharge. "Interim aftercare placement for these children must be avoided."

15. Availability of Information on Mental Health. When surveyed about whether social workers in their offices possessed directories of psychiatric hospitals, mental health clinics, and residential facilities, 58% to 61% (21/22) of the respondents replied yes. As seen in Figure 5, however, only 39% reported that social workers had directories of mental health professionals.

16. Dissemination of Mental Health Information. Nearly two-thirds (23) of the 36 respondents indicated that there was an individual in their office, who was responsible for identifying mental health resources and sharing this information with the social workers. (See Figure 6.) When asked to identify the person's job title, 56% (13) of the 23 were able to name a single individual, who carried that job function, namely the Area Program Manager (APM), Program Development Specialist (PDS), the Assistant Area Director, or the Regional Administrator. The rest (10) reported that the responsibility was shared by various staff in their offices.

17. Mental Health Data Collection Instruments. Office staff were asked to identify any forms, logs, or data collection instruments used to gather information on mental health behaviors, needs and resources. Ten respondents stated that none exist in their offices. Those who identified data sources, most frequently mentioned using manual logs - intake logs to profile children needing mental health services, of 766 children and mentally retarded/medically involved children, and logs reflecting requests made by staff for PAS specialized foster care. Respondents next mentioned case records as their source of mental health information, followed by referral forms such as the AAU Referral Tracking Sheet and Forms and DMH Referral forms. Other respondents mentioned accessing data sources outside of the office - the DMH prescreening team (for the evaluation), participation in the DMH quality assurance program reviews, and needs assessments from OFC and Area Boards. It is clear from the responses to these questions that there is currently no systematic, uniform method in the field for obtaining profile, resource, and needs information on children with mental health problems.

Table 1. Waiting Time for Children Placed in Hospitals
or Entering Programs (18 Respondents)

Time Period Before Placement/Entry	Number (Percent) of Children By Screen In Category	
	Committable	Would Benefit
0-2 Days	206 (80%)	88 (39%)
3-6 Days	23 (9%)	40 (18%)
1-2 Weeks	15 (6%)	45 (20%)
>2-4 Weeks	6 (2%)	30 (14%)
>1-2 Months	0	9 (4%)
Over 2 Months	2 (1%)	12 (5%)
Missing	5 (2%)	0
TOTAL	257 (100)	224 (100%)

Table 2. Number of Times Specific Resources Were Mentioned by
Respondents as being Provided to Children Screened Out and Not
Referred to the Teams

Screened Out

Emergency Shelter (15)
Home with Parents/Relatives (12)
Foster Care (10)
Community Resid. (7)
Private Hospitals (7)
Specialized Fos. Care (5)

Not Referred

Emergency Shelters (12)
Foster Care (11)
Private Hospitals (10)
Therapeutic/Counseling (7)
Home-Parents/Relatives (7)
Specialized Fos. Care (4)

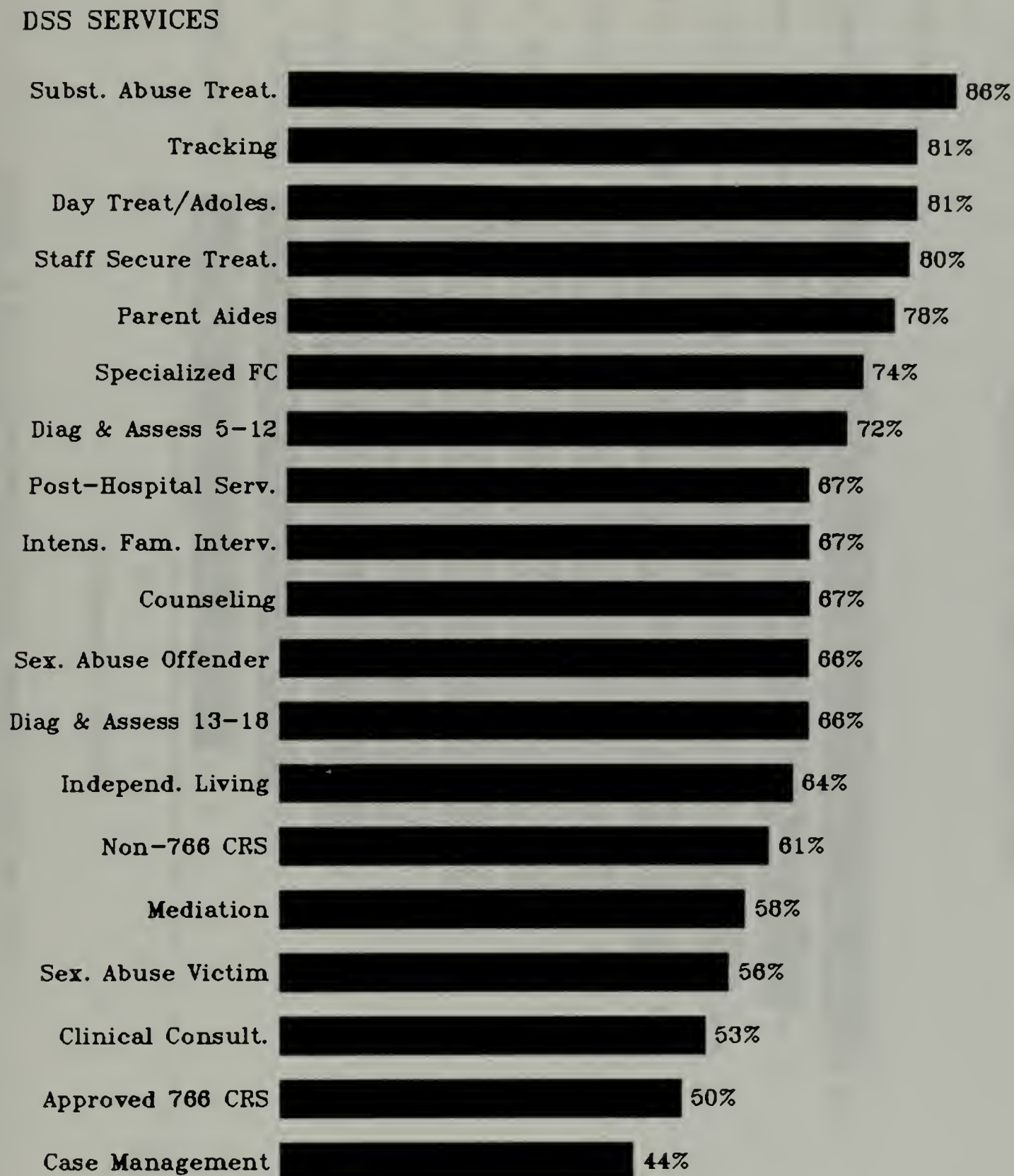
Table 3. Were Resources Appropriate?

Type of Responses	Number of Surveys	
	Screened In	Screened Out/Not Referred
Yes	23 (64%)	11 (31%)
No	4 (11%)	13 (36%)
Mixed	4 (11%)	8 (22%)
Missing	5 (14%)	4 (11%)
	36 (100%)	36 (100%)

Table 4. Does the DSS/PAS Agency Relationship with the DMH Team Affect the Workers' Ability to Access Mental Health Services

Affects Access:	Yes	No	Don't Know	Missing	Total
DMH Relationship					
Satisfactory	16	5	4	1	26 (72)
Unsatisfactory	3	3	0	0	6 (17)
Missing	2	0	0	2	4 (11)
Total	21 (59)	8 (22)	4 (11)	3 (8)	36 (100)

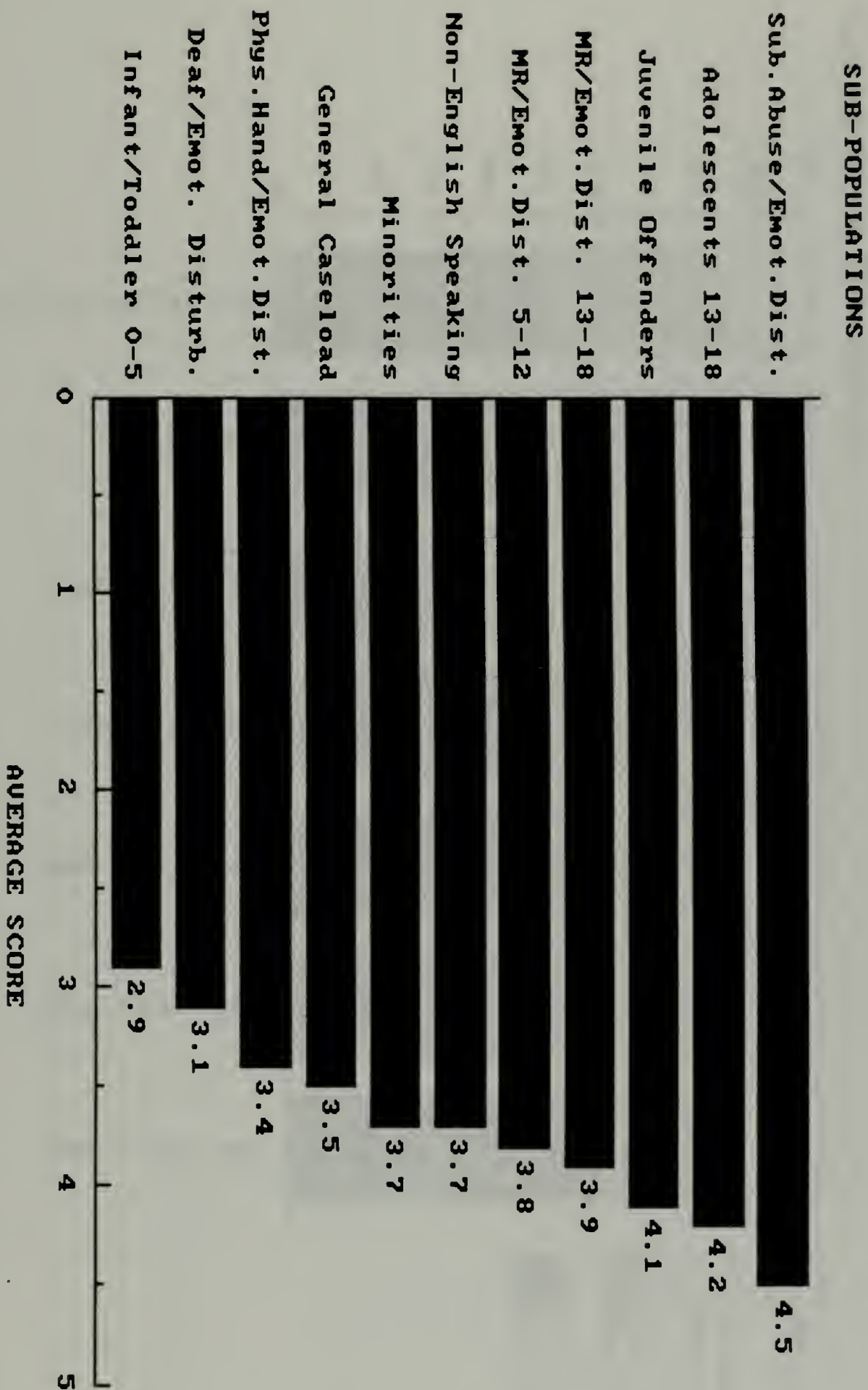
**FIGURE 1. COMPARISON OF RESPONDENTS NEED FOR
MENTAL HEALTH RESOURCES BY DSS SERVICE**



PERCENT OF RESPONDENTS (36)

Respondents identified the need for more DSS services and services needed but not currently provided. See attachment 3 for supporting data.

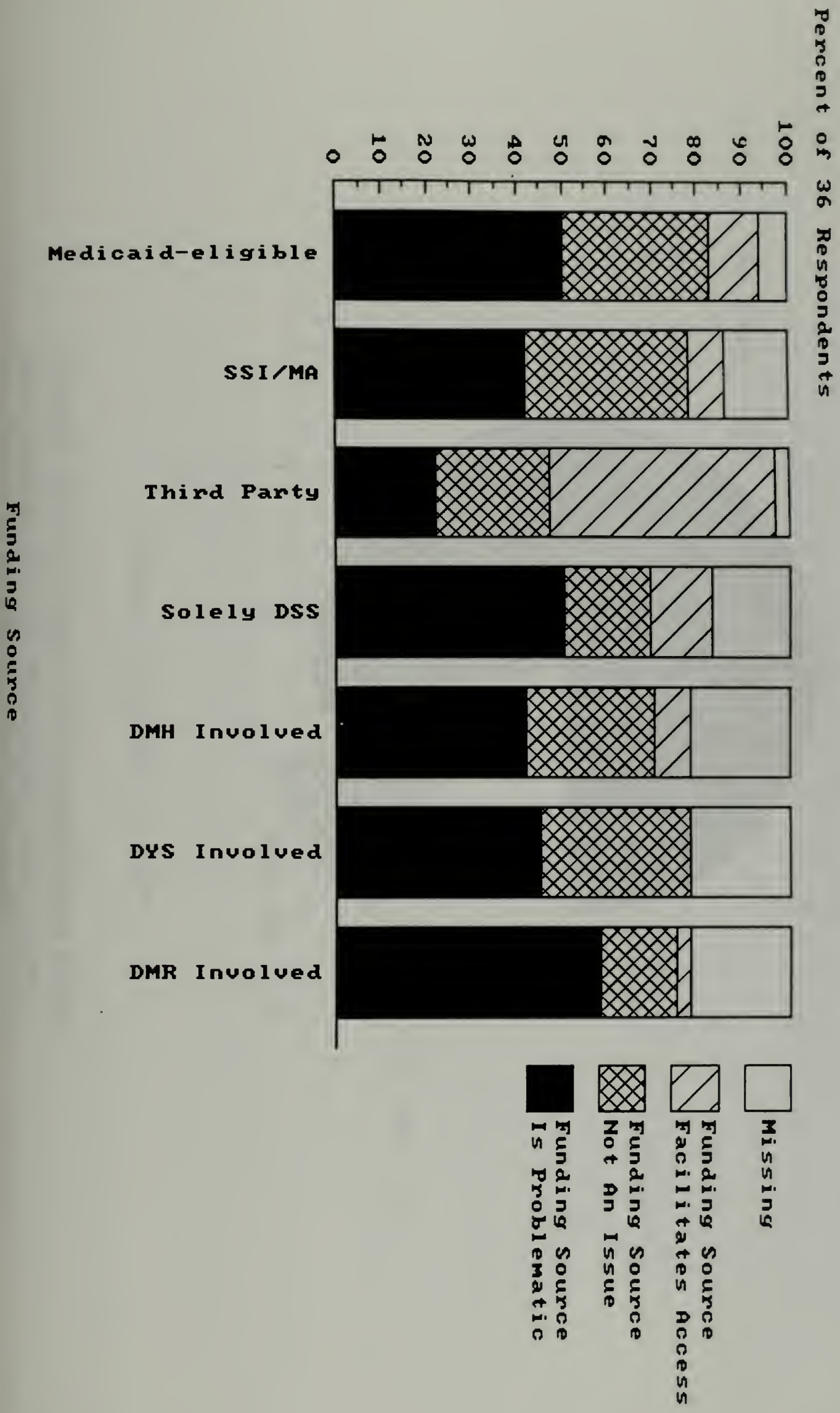
FIGURE 2. DEGREE OF NEED FOR MENTAL HEALTH
RESOURCES BY SUB-POPULATION



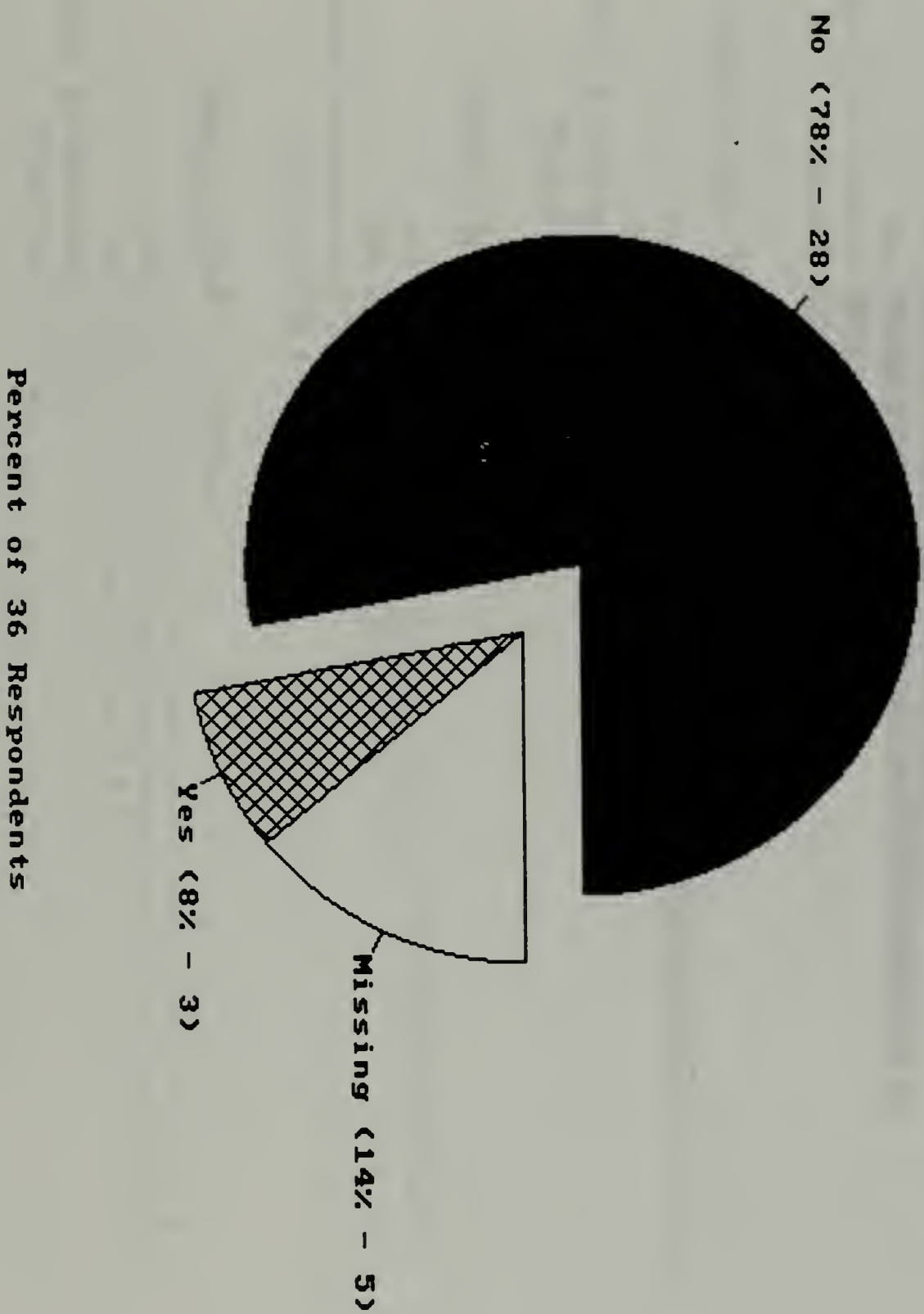
Note: Five points=critical need, 4=high need, 3=moderate need, 2=low need, 1=no need. Ave. Score = # Respondents/Total Points.

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FIGURE 3. ACCESSABILITY OF MENTAL HEALTH RESOURCES BY FUNDING SOURCE

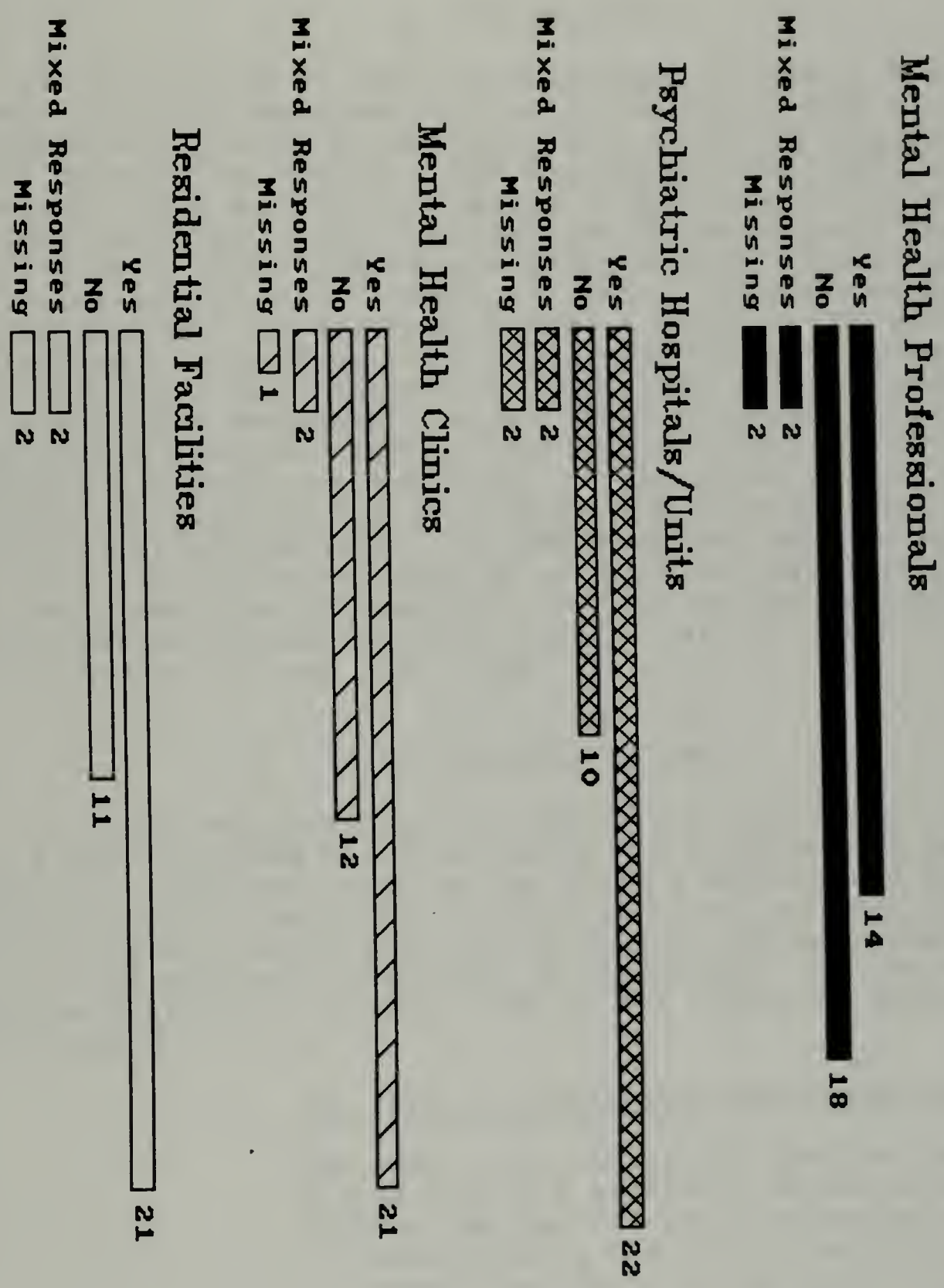


**FIGURE 4. DO CHILDREN PLACED IN PSYCHIATRIC
HOSPITALS REMAIN TOO LONG?
(PERCENT OF 36 RESPONDENTS)**



Seventy eight percent of the respondents stated that children do not remain too long; in fact, some are not hospitalized long enough.

FIGURE 5. DO SOCIAL WORKERS HAVE DIRECTORIES
OF VARIOUS MENTAL HEALTH RESOURCES?



Note: Data are number of respondents out of 36.
A mixed response indicated that some sws in an
office have directories while others did not.

DEPARTMENT OF MENTAL HEALTH DEPARTMENT OF SOCIAL SERVICES
INTERAGENCY AGREEMENT ON CRISIS INTERVENTION AND PSYCHIATRIC
HOSPITALIZATION FOR CHILDREN IN THE CARE OR CUSTODY OF THE
DEPARTMENT OF SOCIAL SERVICES

I. INTRODUCTION

It is the aim of both the Department of Mental Health ("DMH") and the Department of Social Services ("DSS") to provide children with the services they need in the most appropriate and least restrictive setting. DSS and DMH believe that, whenever possible, clinical services should be provided in the child's natural environment, and hospitalization prevented. Therefore, as of July 1, 1988, the DMH emergency service system shall be the exclusive method used to evaluate (and to assess what services may be necessary or appropriate for) a child in DSS care or custody who is in psychiatric crisis and believed to be in need of psychiatric hospitalization. This shall include adolescents who experience psychiatric crisis while in placement at a DSS Commonworks Program. Neither DSS nor DMH shall use funds to purchase a psychiatric evaluation to determine whether a child requires psychiatric hospitalization, or what services may be necessary or appropriate. The DMH emergency service system shall be the exclusive method used to obtain such evaluations by DSS and DMH. When the DMH emergency service system determines that a crisis can be managed without hospitalization, refer to Section II paragraph 1(b) and 1(c) below.

II. DIAGNOSIS BY DMH

1. The DMH emergency service system will pre-screen and evaluate each referred child to assess the child's need for hospitalization. DSS shall provide the child's medical and mental health history (including information on all medications), the child's legal status, and any third-party reimbursement (including Medicaid) available to the child. The DMH emergency service staff will arrive at one of the following diagnostic conclusions:

- (a) The child is committable and needs hospitalization.

DMH staff will locate and arrange for an appropriate and available hospital bed. Neither DMH nor DSS will assume any obligation to hospitalize a child in a facility that does not accept Medicaid (or other third-party reimbursement available to the child). If no hospital bed is available, DMH is responsible for locating and arranging for an appropriate non-hospital placement.

- (b) The child is not commitable, but would benefit from hospitalization.

DMH will attempt to locate and arrange for a hospital bed. Neither DMH nor DSS will assume any obligation to hospitalize a child in a facility that does not accept Medicaid (or other third-party reimbursement available to the child). If an appropriate hospital bed is not immediately available to DMH, then the DSS Area Director and the DMH Area Director shall proceed according to their Joint Crisis Plan. (See Paragraph III below for a description of this Joint Crisis Plan.) The Joint Crisis Plan shall be in effect until the crisis abates, or until an appropriate therapeutic intervention is available, which might or might not be hospitalization. If the Joint Crisis Plan requires money expenditure(s), said expenditure(s) shall be shared equally (50/50) between DSS and DMH, for a maximum of 72 hours. If the crisis has not abated within 72 hours, the Joint Crisis Plan must be reviewed and updated.

- (c) The child is not commitable, nor would s/he benefit from hospitalization.

DSS is responsible for providing appropriate non-hospital services for the child, drawing on the resources of both DSS and DMH.

2. DMH provides secure beds for commitable children. These beds are reserved for such children. For children who are determined not to be commitable but would benefit from hospitalization, DMH will access other non-secure psychiatric beds in private and general hospitals.

III. JOINT CRISIS PLAN

On or before July 1, 1989 each DSS and DMH Area Director shall meet to develop a Joint Crisis Plan, tailored to the resources and characteristics of the area, which outlines the procedure that will be followed and the resources that will be utilized to serve children who are waiting for a psychiatric hospital bed. This Joint Crisis Plan shall be completed and submitted to the

Regional Directors of DSS and DMH no later than August 1, 1989 for their approval or modification. No later than September 1, 1989, the Regional Directors of DSS and DMH will submit each area Joint Crisis Plan to the DSS and DMH Central Office for final approval. Thereafter, this Joint Crisis Plan shall govern, as set forth above.

IV. DISCHARGE PLANNING

DSS is responsible for post-hospital placement. DSS is responsible for participating in the hospital's treatment planning and review process, which includes discharge planning, and for assuring that post-hospitalization services have been arranged, so that no child remains in a hospital longer than is medically necessary. DMH is responsible for providing sufficient advance notice to DSS regarding all meetings and discharge date, to enable DSS to meet this responsibility.

V. CASE MANAGEMENT

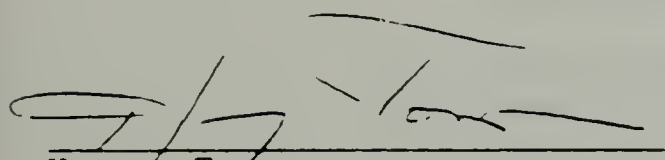
DSS will maintain primary case management responsibility for a child hospitalized under this agreement. If a child is hospitalized in a DMH facility or in designated DMH hospital beds, the DMH case manager is also responsible for attending treatment planning and review meetings.

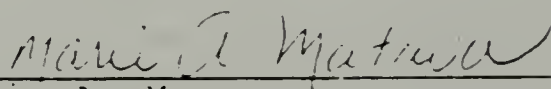
VI. PROCEDURES

1. All disputes between DSS and DMH regarding the application of this Agreement to a particular case shall be addressed as follows: the DSS and DMH Area Directors, respectively, shall discuss the case and try to resolve the dispute. If resolution cannot be reached, both Area Directors shall promptly refer the case to their respective Regional Directors for attempted resolution.

2. All disputes between DSS and DMH regarding the application of this Agreement in general shall be addressed as follows: the respective Commissioners, or their designees appointed for this purpose, should attempt to resolve the disagreement. If the Commissioners or their designees are unable, after a reasonable effort, to resolve the dispute, this matter should be referred to the Secretary of Human Services whose decision is final and binding on all parties.

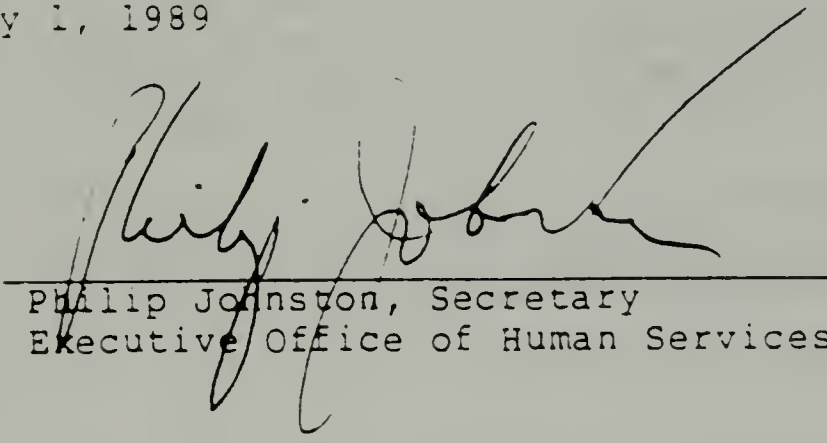
3. See Appendix A (attached) for specific procedures and responsibilities.


Henry Torres
Commissioner
Department of Mental Health


Marie A. Matava
Commissioner
Department of Social Services

Dated: May 1, 1989

APPROVED:


Philip Johnston, Secretary
Executive Office of Human Services

APPENDIX A

1. Each DMH Area is expected to have a generic emergency service system which will provide core emergency services 24 hours a day, 7 days a week to any citizen in the Commonwealth experiencing acute psychiatric disturbance. Specific services which shall be provided include:
 - short-term, face-to-face mental health evaluation
 - diagnosis
 - prescreening for psychiatric inpatient hospitalization
 - medication
 - crisis treatment
 - information
 - consultation and referral
2. The DMH emergency service staff will make an initial assessment of any child's need for the above listed emergency services based on a call from DSS. If DMH emergency service staff determine that the child should be seen, emergency service staff will make every attempt to see the child within a maximum of two hours from the initial call.
3. The DMH emergency services system will maintain the capacity to service linguistic minorities and the hearing impaired, DSS shall make every attempt to call DMH ahead of time to notify them of such need.
4. For any child in DSS care or custody who is determined by DMH to be commitable, or not commitable but would benefit from hospitalization, DSS shall:
 - (a) Arrange for any necessary permissions to medicate;
 - (b) Contact the child's parents;
 - (c) Make every attempt to have the parent accompany the child to the hospital, sign the child into the hospital, and authorize medication including the use of antipsychotic medication. If the parent is unavailable, DSS staff must accompany the child to the hospital and will sign the child into the hospital:

- (d) Maintain primary case management responsibility including follow-up services, liaison with the child's family, etc;
 - (e) Be responsible for all post-hospitalization services including out-of-home placement if necessary;
 - (f) Attend the initial treatment planning meeting and subsequent treatment plan review meetings in order to prepare for the patient's timely discharge to the community.
 - (g) Should a child's planned discharge date be moved ahead, DSS shall be notified by the child's DMH Case Manager, at least seven (7) days prior to the new discharge date. Together, every effort shall be made to locate an appropriate post-discharge placement and provide ongoing services.
 - (h) If a child in psychiatric crisis is known to DSS but is not in DSS care or custody, DSS shall work with the parents of such child to encourage them to use the DMH emergency services system.
5. For any child in DSS care or custody who is determined by DMH to be commitable, or not commitable but would benefit from hospitalization, DMH shall:
- (a) Arrange for the child's hospital admission;
 - (b) Be responsible for arranging transportation to the hospital from the DMH screening team, if the child cannot be transported to the hospital or other placement by family or by ambulance using third party reimbursement;
 - (c) Complete the "Psych Under 21" form certifying that they approve the need for psychiatric inpatient services.

CHILD MALTREATMENT STATISTICS

JANUARY 1 - DECEMBER 31, 1989

Department of Social Services

Marie A. Matava, Commissioner

Executive Office of Human Services

Philip W. Johnston, Secretary

Commonwealth of Massachusetts

Michael S. Dukakis, Governor

CHILD MALTREATMENT STATISTICS

JANUARY 1 - DECEMBER 31, 1989

Prepared by: Antone C. Felix III

Research, Evaluation, and Planning Unit

Julia Herskowitz, Director

Office for Professional Services

Gerald W. Robinson, Assistant Commissioner

June, 1990

Department of Social Services

Marie A. Matava, Commissioner

150 Causeway Street

Boston, MA 02114

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CHILD MALTREATMENT STATISTICS 1989

I. CHILDREN REPORTED AND INVESTIGATED

During 1989, 70,713 children were reported to the Department of Social Services (DSS), a 15% increase over 1988 (Table 1). The increases in the number of children reported over the past two years are the largest since 1984. Changes from 1988 to 1989 in number of children reported by geographic location were:

Western Massachusetts	+13%
Northeastern Massachusetts	+20%
Southeastern Massachusetts	+19%
Boston/Brookline	+7%

In 1989, nonmandated sources reported 18% more children than in 1988 while mandated sources reported 11% more children. Major groups which reported relatively higher numbers of children in 1989 as compared to 1988 were: anonymous callers (+23%), medical personnel (+21%), DSS social workers (+20%), law enforcement personnel (+15%), and school personnel (+12%).

The following reporting groups had the highest supported finding rates: medical personnel, law enforcement personnel, DSS social workers, and foster parents each had a rate of 52% (Table 2). This rate is defined as the percentage of children reported that had an investigation which resulted in a supported finding of maltreatment. Anonymous sources reported the highest number of children, but they had a relatively low support rate as did mothers and fathers not living with their children (Table 2).

Of the 70,713 children reported in 1989, 4% were screened-in as needing an emergency response and 62% were screened-in as nonemergencies (Table 3). The percentage of children screened-in ranged from 59% in Western Massachusetts to 74% in Boston/Brookline.

Investigations of maltreatment involved 42,590 children (Table 4); 22,532 (53%) of these children were found to have been victimized (children with "supported investigations").¹ Boston/Brookline had the highest percentage of investigations that resulted in a supported finding (61%) and Southeastern Massachusetts had the lowest (50%) (Table 4).

Figure 1 summarizes the geographic distribution of children reported, investigated, and supported. The highest maltreatment counts were recorded in Western Massachusetts.

¹ As with children reported, these are duplicate counts since a child may have been reported and investigated more than once during 1989. Removing duplication reduces the number of children reported by 30% and those with supported investigations by 9%. Appendix Table A provides duplicated and unduplicated counts of reported children and children with supported investigations by type of maltreatment. Counts of the actual number of reports and supported investigations involving these children are also included. NOTE: The term "supported" is equivalent to "substantiated" which was used in statistical reports produced prior to 1988.

Table 1. Children Reported, Investigated, and with a Supported Investigation of Maltreatment from 1983 to 1989.

Children						
Calendar Year	Reported No.	Annual Change %	Investigated No.	Annual Change %	Substantiated No.	Annual Change %
1983	36,258	-----	26,204	-----	12,518	-----
1984	46,393	28	34,326	31	16,515	32
1985	49,320	6	35,971	5	18,203	10
1986	51,759	5	35,085	-2	18,291	*
1987	52,391	1	33,832	-4	17,356	-5
1988	61,506	17	37,229	10	18,957	9
1989	70,713	15	42,590	14	22,532	19

(*) Less than 1% after rounding-off.

Research, Evaluation, and Planning Unit

Massachusetts Department of Social Services

SOURCE: Monthly Report and Investigation Activity (ASSIST Reports WTDSS824A and WTDSS742A).

Table 2. Supported Finding Rates for Reporters of Maltreatment during January 1 - December 31, 1989 (1)

Report Source	Number of Reported Children	Percent of Reported Children W/Supported Investigations
Medical Personnel	9,019	52%
Court	794	40%
Law Enforcement Agency	6,519	52%
School Personnel	6,642	51%
Day-Care Provider	1,252	38%
Poster Parent	195	52%
Other Substitute Care Provider	159	43%
Private Social Service Agency	2,545	41%
Other Mass. State agency	1,493	24%
Out-of-State Agency	252	30%
DSS Social Worker	3,131	52%
Other Mandated	5,902	39%
Total Mandated	37,903	47%
Self (Victim)	483	50%
Mother in Home	1,032	44%
Father in Home	300	28%
Stepparent	117	26%
Sibling	203	40%
Other Relative	3,177	36%
Mother Out of Home	484	13%
Father Out of Home	2,547	18%
Anonymous	14,450	20%
Other Nonmandated	7,619	28%
Total Nonmandated	30,412	25%
All Sources	68,315 (*)	37%

(1) Rate is defined as the percentage of children reported that had an investigation which resulted in a supported finding of maltreatment. It should be noted that the type of maltreatment supported may not be the type of maltreatment reported.

(*) A total of 70,713 children were reported in 1989 (data on 2,398 screened-out children were lost due to expungement).

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date January 16, 1990)

Table 3. Children Reported for All Types of Maltreatment, by Geographic Location and Screening Decision during January 1 - December 31, 1989.

Geographic Location	Screening Decision						Total Children Reported	
	In		In		Out			
	Non-Emergency		Emergency				No.	%
	No.	%	No.	%	No.	%	No.	%
West	12,971	57	544	2	9,186	40	22,701	32
Northeast	11,104	61	629	3	6,492	36	18,225	26
Southeast	11,139	66	599	4	5,181	31	16,919	24
Boston/Brookline	8,710	68	760	6	3,398	26	12,868	18
STATE	43,924	62	2,132	4	24,257	34	70,713	100

Note: These maltreatment statistics represent counts of children rather than the number of reports. For example, a report involving three children is counted as three children reported rather than one report.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services

SOURCE: Monthly Report and Investigation Activity (ASSIST Reports WTDSS742A).

Table 4. Children Investigated for All Types of Maltreatment by Geographic Location and Investigation Decision during January 1 - December 31, 1989

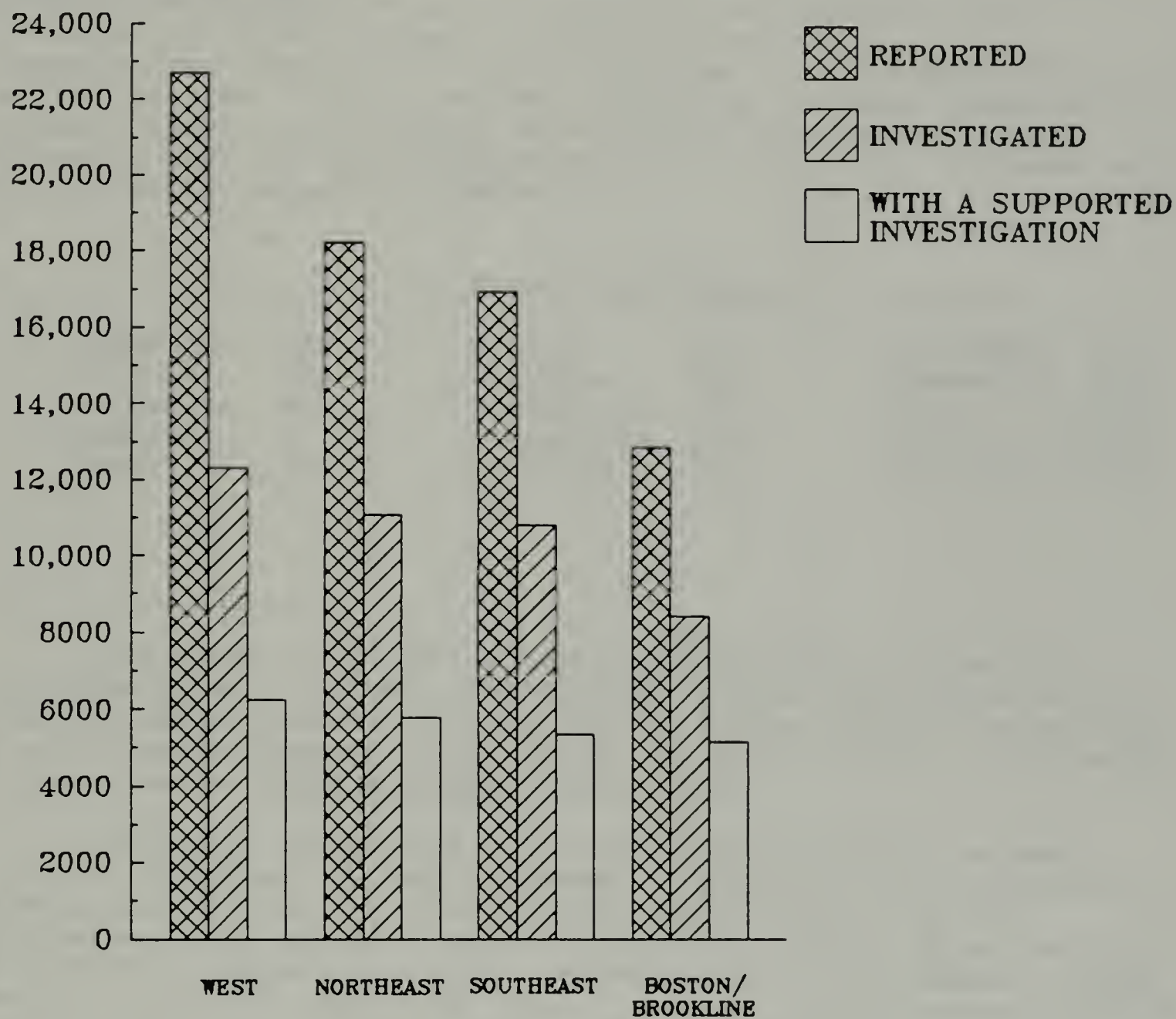
Geographic Location	Investigation Decision					
	Supported No.	Supported %	Unsupported No.	Unsupported %	Total No.	Total %
West	6,257	51	6,033	49	12,290	29
Northeast	5,775	52	5,294	48	11,069	26
Southeast	5,353	50	5,452	50	10,805	25
Boston/Brookline	5,147	61	3,279	39	8,426	20
STATE	22,532	53	20,058	47	42,590	100

Note: These maltreatment statistics represent counts of children rather than the number of investigations or supported investigations. For example, an investigation involving three siblings which resulted in a supported investigation of abuse for two of the children is counted as three children investigated, two children with supported investigations and one child with an unsupported investigation.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: Monthly Report and Investigation Activity (ASSIST Reports MTDSS742A).

FIGURE 1. CHILDREN REPORTED, INVESTIGATED,
AND SUPPORTED FOR MALTREATMENT
DURING JANUARY 1 – DECEMBER 31, 1989

NUMBER OF CHILDREN



DSS GEOGRAPHIC LOCATIONS

Research, Evaluation and Planning Unit
Massachusetts Department of Social Services

Source: Monthly Report and Investigation Activity (ASSIST Reports NTDSS742A)

II. REPORTING RATES BY COUNTY AND CITY²

The numbers of children reported for maltreatment by counties and selected cities (residence of maltreated children) are presented in the Appendix (Tables B through E).³ In order to compare the incidence of maltreatment among counties and cities of differing population sizes, reported child counts were converted to rates--number of children reported (unduplicated count) per 10,000 children up to 19 years old in a particular area.⁴ Six counties, Franklin, Suffolk, Berkshire, Hampden, Essex, and Bristol, had rates that exceeded the statewide rate of 321 children reported per 10,000 children in Massachusetts (Appendix, Table B).

Reporting Rates					
Franklin	505	Bristol	330	Nantucket	232
Suffolk	500	Statwide	321	Hampshire	228
Berkshire	453	Worcester	297	Dukes	218
Hampden	407	Barnstable	264	Middlesex	209
Essex	330	Plymouth	263	Norfolk	159

² Reported incidence, unlike substantiated (supported) incidence is more likely to represent a consistent portion of true incidence (Zuravin, S. J. and R. Taylor. 1987. The ecology of child maltreatment: identifying and characterizing high-risk neighborhoods. Child Welfare, 66:497-506).

³ Selected cities had 300 (unduplicated count) or more children reported for maltreatment. Please note that the total number of children reported (unduplicated count) for all maltreatment in Appendix Table B, 47,977, differs from the total presented in Appendix Table A, 49,661. This discrepancy occurs because data are taken from two different sources--Annual ASSIST Extract Tapes and Monthly ASSIST Reports (NTDSS742A)--which are produced on different dates and consequently are affected differently by the timing of expungement and data entry.

⁴ The populations of children (up to 19 years old) by geographic area were taken from 1990 population estimates made by the Massachusetts Institute of Social and Economic Research at the University of Massachusetts, Amherst.

Among cities and towns, the highest rates were in Holyoke, North Adams, Lynn, Greenfield, Chelsea, and Lawrence. Ten municipalities had higher maltreatment rates than Boston (Appendix, Table D).

Holyoke	848	Boston	501	Haverhill	396
North Adams	762	Chicopee	493	Salem	380
Lynn	696	Fitchburg	475	Attleboro	369
Greenfield	688	Taunton	458	Quincy	299
Chelsea	637	Fall River	454	Somerville	289
Lawrence	634	Revere	449	Cambridge	277
Lowell	589	Worcester	448	Waltham	258
Brockton	541	Malden	414	Framingham	250
Pittsfield	537	Westfield	410	Weymouth	234
New Bedford	532	Springfield	399		

Municipalities with the largest reporting rates for specific types of maltreatment were:

Sexual Abuse		Neglect		Physical Abuse		Emotional Maltreatment	
Holyoke	109	Lynn	499	North Adams	250	Brockton	152
North Adams	105	Lawrence	441	Holyoke	240	North Adams	133
Greenfield	103	Lowell	411	Greenfield	220	Lowell	118
Brockton	82	Chelsea	409	Chelsea	212	Quincy	117
New Bedford	81	Brockton	377	Lawrence	209	Greenfield	117

The most dramatic change occurred in Holyoke where the reporting rate of sexual abuse rose from 57 in 1988 to 109 in 1989.

National studies have reported a strong relationship between poverty and physical neglect.⁵ The association is much less pronounced for other forms of maltreatment. Unlike neglect, sexual abuse does not have a strong association with poverty; it is reported in families at all income levels.

⁵ U.S. Dept. of Health and Human Services. 1981. National Study of the Incidence and Severity of Child Abuse and Neglect.

Russell, A. B. and C. M. Trainor. 1984. Trends in child abuse and neglect: a national perspective. The American Humane Association.

III. CHILDREN WITH SCREENED-IN REPORTS

Reporters

Counts of children with screened-in reports by type of maltreatment and specific report source are presented in Table 5. Neglect was the major form of maltreatment among screened-in children--28,625 as compared to 16,257 for physical abuse, 7,438 for emotional maltreatment, and 5,913 for sexual abuse.

The number of children reported by mandated sources exceeded those reported by nonmandated for all forms of maltreatment (Table 5). Several factors contribute to the greater numbers of children reported by mandated sources. Mandated reporters are required by law to report incidents of child maltreatment, they have more opportunities to observe children because of the nature of their jobs, and they are more likely to have received training in the recognition and reporting of maltreated children.

Sexual abuse and to a lesser degree physical abuse, were distinguishable from neglect and emotional maltreatment by their much larger proportions of mandated reporters--76% and 62%, respectively. In the case of sexual abuse, medical personnel and DSS social workers are the primary reporters (Table 5). The difficulty in recognizing behavioral signs of sexual abuse and the secrecy that prevails in families where sexual abuse is taking place⁶ may explain the greater numbers of children reported by these trained professionals.

Anonymous callers are the leading reporters of neglect, physical abuse, and emotional maltreatment (Table 5). Although they have a low supported finding rate, anonymous reporters still account for a large number of the children whose investigations result in a supported finding of maltreatment (Table 2).

Perpetrators

Seventy-nine percent of the children with screened-in reports of sexual abuse were allegedly victimized by only one perpetrator (Table 6). Of these sole perpetrators, 56% were family members and 26% were fathers. The principal perpetrators, fathers, were followed by the categories "Unknown," "Other Relative," and "Other Unrelated Caretaker." Mothers were the primary perpetrators of other types of maltreatment, especially neglect (Table 6). The proportion of children maltreated by fathers was significantly greater for physical abuse and emotional maltreatment than for neglect.

⁶ De Jong, A. R. 1985. The medical evaluation of sexual abuse in children. Hospital and Community Psychiatry, 36:509-512.

Table 5. Children with Screened-In Reports by Report Source and Type of Maltreatment
during January 1 - December 31, 1989.

Children with Screened-In Reports									
Report Source		Sexual Abuse		Neglect		Physical Abuse		Emotional Maltreatment	
		No.	%	No.	%	No.	%	No.	%
Mandated	Medical Personnel	1,205	20	3,772	13	1,998	12	701	9
	DSS Social Worker	702	12	1,358	5	778	5	392	5
	School Personnel	643	11	2,304	8	2,683	17	750	10
	Court/Law Enforcement Agency	521	9	3,499	12	1,678	10	879	12
	Private Social Service Agency	427	7	693	2	700	4	272	4
	Other Agency (1)	120	2	567	2	269	2	126	2
	Substitute/Day Care (2)	226	4	451	2	570	4	116	2
	Other Mandated	652	11	2,123	7	1,410	9	555	7
Total Mandated		4,496	76	14,767	52	10,086	62	3,791	51
Nonmandated	Self (Victim)	45	1	147	1	235	1	85	1
	Parent/Relative	592	10	3,375	12	1,578	10	944	13
	Other Nonmandated	356	6	3,610	13	1,585	10	940	13
	Anonymous	424	7	6,726	23	2,773	17	1,678	23
Total Nonmandated		1,417	24	13,858	48	6,171	38	3,647	49
All Sources		5,913	100	28,625	100	16,257	100	7,438	100

(1) Includes other Massachusetts state agencies and out-of-state agencies.

(2) Includes day-care provider, foster parent, and other-substitute-care provider.

Research, Evaluation, and Planning Unit

Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1989).

Table 6. Children with Screened-In Reports by Alleged Perpetrator's Relationship and Type of Maltreatment during January 1 - December 31, 1989.

Children with Screened-In Reports									
Perpetrator's Relationship		Sexual Abuse		Neglect		Physical Abuse		Emotional Maltreatment	
		No.	%	No.	%	No.	%	No.	%
Single Perpetrator	Mother	263	4	17,714	62	6,024	37	3,019	41
	Father	1,233	21	1,368	5	3,198	20	1,108	15
	Stepmother	8	*	6	*	53	*	10	*
	Stepfather	259	4	43	*	436	3	90	*
	Sibling	167	3	37	*	51	*	8	*
	Other Relative	665	11	321	1	367	2	96	*
	Unrelated-Adult-In-Home	350	6	89	*	614	4	116	2
	Other Unrelated Caretaker	655	11	123	*	248	2	65	*
	Legal Guardian	10	*	66	*	53	*	20	*
	Poster Mother	8	*	132	*	129	1	52	*
	Poster Father	42	1	11	*	40	*	8	*
	Other Substitute Care Provider	94	2	81	*	118	1	40	*
	Family Day-Care	32	1	47	*	20	*	8	*
	Center Day-Care	38	1	21	*	27	*	7	*
	Unknown	741	13	180	1	492	3	20	*
	Not Applicable	8	*	7	*	4	*	2	*
	Other	102	2	23	*	46	*	16	*
Multiple Perpetrators	Both Parents	324	5	5,448	19	2,290	14	1,797	24
	Mother and Stepfather	87	1	397	1	341	2	172	2
	Mother and Relative	157	3	524	2	258	2	101	1
	Father and Stepmother	2	*	55	*	43	*	29	*
	Father and Relative	71	1	95	*	83	1	29	*
	Mother & Unknown/Unrelated	450	8	1,593	6	1,109	7	523	7
	Father & Unknown/Unrelated	50	1	86	0	80	*	44	*
	Other Combinations (1)	97	2	158	1	133	1	58	*
Total		5,913	100	28,625	100	16,257	100	7,438	100

(*) Less than 1% after rounding-off.

(1) Other combinations of the single perpetrator categories presented above.

Research, Evaluation, and Planning Unit

Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

IV. CHILDREN WITH SUPPORTED INVESTIGATIONS

Investigations which resulted in a supported finding of neglect predominated. A total of 14,048 children were found to have been neglected as opposed to 6,768 for physical abuse, 4,506 for emotional maltreatment, and 2,707 for sexual abuse (Table 7). Neglected children appeared to be evenly distributed across the state (Table 7). Sexual and physical abuse seemed to be more concentrated in Western Massachusetts and emotional maltreatment in Northeastern Massachusetts.

Age, Sex, and Ethnicity of Children

Figure 2 displays the age distributions of children sexually abused, neglected, physically abused, and emotionally maltreated.

Sexually abused children are predominantly white (76%) (Table 8) and female (72%) (Fig. 3). The number of girls with supported investigations exceeded the number of boys at all ages (Fig. 3). Female victims were most numerous at ages 4 and 15 years. The number of male victims peaked at 6 years old then declined with increasing age.

Females accounted for 49% of the children with supported investigations of neglect. The distribution of girls and boys across all ages were similar--highest at ages under one year and gradually diminishing with increasing age of the children (Fig. 3). Fifty-five percent of these children were white; however, compared to sexual abuse, the proportion of black children almost tripled (9% to 23%) while the proportion of Hispanic children almost doubled (9% to 14%) (Table 8). As stated previously, national studies have reported a strong relationship between poverty and neglect.

Fifty percent of the physically abused children were female and 60% were white (Table 8). The proportion of Hispanic children was the same as for neglect, but the proportion of black children dropped to 16%. Physically abused boys outnumbered girls at all ages under 12-13 years (Fig. 4). At ages 13 and older, girls were more numerous than boys. The number of female victims peaked at 14 years old.

Fifty-two percent of all children emotionally maltreated were female and 72% were white (Table 8). The proportions of black and Hispanic children were not much different than those for sexual abuse (Table 8). In general, the numbers of emotionally maltreated boys and girls followed a similar gradual decline up to the age of 12 years (Fig. 4). From 13 to 17 years, females were distinctly more numerous than males.

Grouping maltreated children in Massachusetts by the age categories used in national studies, yields the following relative percentages.

Age (yrs)	Sexual Abuse	Neglect	Physical Abuse	Emotional Maltreatment
0 - 5	35%	54%	32%	39%
6 - 11	35%	30%	35%	36%
12 - 17	<u>30%</u>	<u>16%</u>	<u>33%</u>	<u>25%</u>
	100%	100%	100%	100%

Geographic Variations

Changes from 1988 to 1989 in the Number of Children with Supported Investigations⁷

From 1988 to 1989, the total number of children with supported investigations of sexual abuse increased by 6% (Table 9). The largest expansion occurred in Western Massachusetts. This increase was offset somewhat by a 17% reduction in Boston/Brookline. Sexually abused children accounted for 12% of all maltreated children (Table 9). As a percentage of all maltreatment, sexual abuse was highest in the South Central/Blackstone Valley (22%), Fitchburg/Gardner (22%), and Greenfield/Northampton (19%) DSS Areas (Table 9).

Neglected, physically abused, and emotionally maltreated children represented 61%, 29%, and 20%, respectively, of all children maltreated (Tables 10, 11, and 12).⁸ As a percentage of all maltreatment, neglect appeared more concentrated in Boston/Brookline, physical abuse was more prevalent in Western Massachusetts, and emotional maltreatment was more significant in Northeastern and Southeastern Massachusetts (Tables 10, 11, and 12).

⁷ Please note that the total number of children with investigations of maltreatment (23,090) in Table 9 differs from Table 4 (22,532). This occurs because the extract tape data source has a later run-date than ASSIST Report NTDSS742A. Data from a small number of investigations that were not entered on the DSS database in time to be compiled by Report NTDSS742A were entered in time to be recorded on the extract tapes.

⁸ Adding up the relative percentages for sexual abuse, neglect, physical abuse, and emotional maltreatment does not yield 100% since children subjected to more than one form of maltreatment are counted in each maltreatment category.

Neglect, physical abuse, and emotional maltreatment as a proportion of all maltreatment were highest in the following DSS Areas (Tables 10, 11, and 12):

Neglect

S.C.F. Mental Health Center (77%)
Dimock Street/Allston (73%)

Physical Abuse

Fitchburg/Gardner (43%)
Holyoke/Westfield (40%)

Emotional Maltreatment

Cambridge-Somerville/Arlington (39%)
Quincy/Weymouth (37%)
Brockton (34%)

Table 7. Children with Supported Investigations by Type of Maltreatment
during January 1 - December 31, 1989. (1)

Geographic Location	Type of Maltreatment (2)							
	Sexual Abuse		Neglect		Physical Abuse		Emotional Maltreatment	
	No.	%	No.	%	No.	%	No.	%
West	964	36	3,597	26	2,153	32	1,071	24
Northeast	610	23	3,577	25	1,658	24	1,383	31
Southeast	793	29	3,148	22	1,624	24	1,213	27
Boston/Brookline	340	13	3,726	27	1,333	20	839	19
STATE	2,707	100	14,048	100	6,768	100	4,506	100

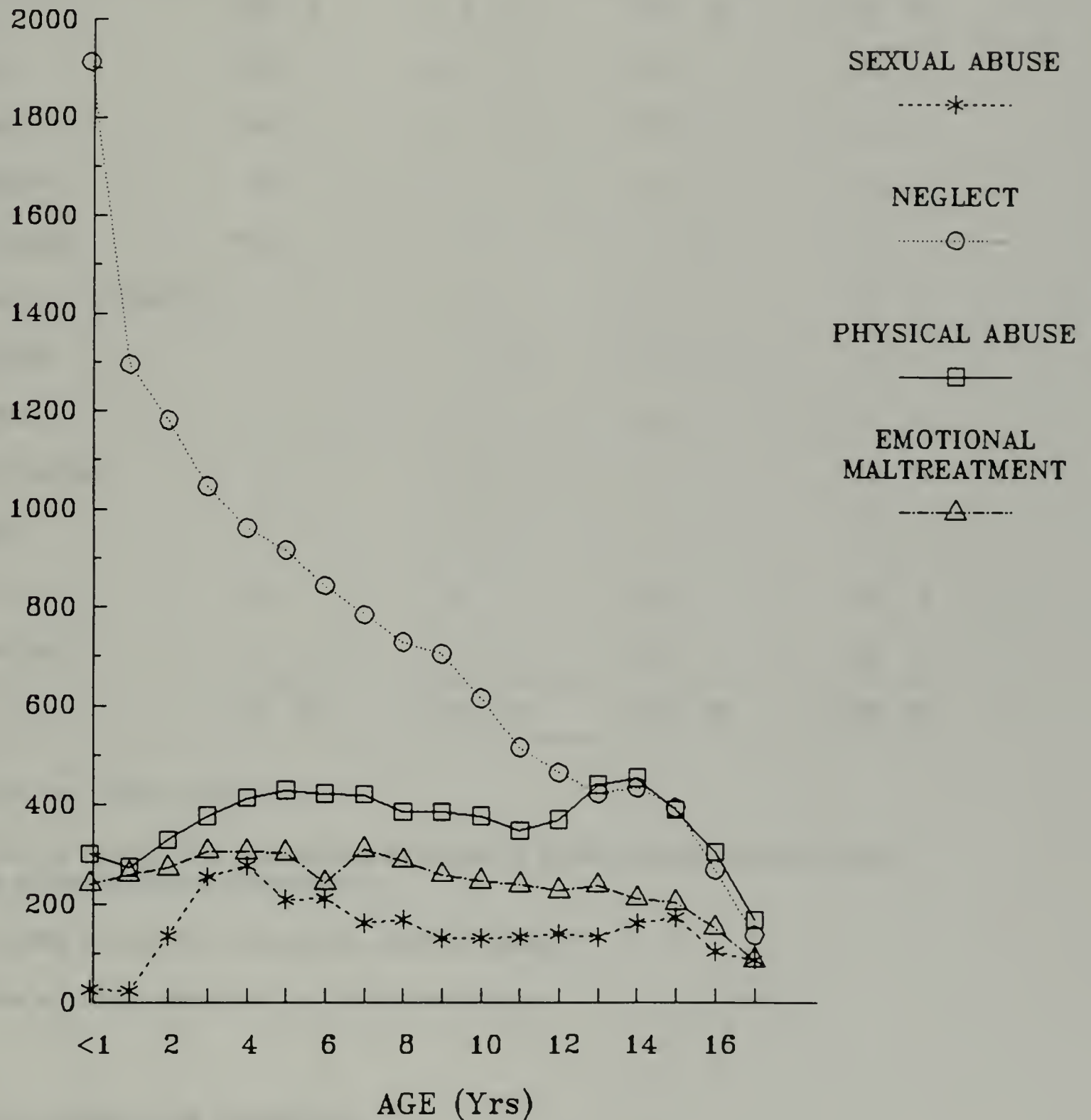
(1) Children whose investigation(s) resulted in a supported finding of maltreatment.

(2) Up to three maltreatment conditions (of seven) may be recorded as supported in an investigation. Consequently, a child subjected to more than one form of abuse/neglect is counted under each abuse/neglect category.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

FIGURE 2. AGE OF CHILDREN WITH
SUPPORTED INVESTIGATIONS OF MALTREATMENT
JANUARY 1 - DECEMBER 31, 1989

NUMBER OF CHILDREN



Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
Source: ASSIST Extract Tapes (Run-Date: 1/16/90)

Table 8. Children with Supported Investigations by Ethnicity and Type
of Maltreatment during January 1 - December 31, 1989. (1)

Children with Supported Investigations								
Ethnicity	Sexual Abuse		Neglect		Physical Abuse		Emotional Maltreatment	
	No.	%	No.	%	No.	%	No.	%
White	2,058	76	7,720	55	4,053	60	3,227	72
Black	245	9	3,197	23	1,091	16	524	12
Hispanic (2)	241	9	1,937	14	930	14	402	9
Portuguese	26	1	137	1	116	2	44	1
Cape Verdean	13	*	198	1	81	1	33	1
Asian/Pacific Islander (3)	8	*	40	*	28	*	12	*
Vietnamese	4	*	41	*	32	*	21	*
Cambodian	1	*	83	1	46	1	8	*
Native American	0	*	15	*	8	*	4	*
Laotian	1	*	11	*	3	*	0	*
Other	44	2	288	2	160	2	103	2
Unspecified	66	2	381	3	220	3	128	3
Total	2,707	100	14,048	100	6,768	100	4,506	100

(*) Less than 1% after rounding-off.

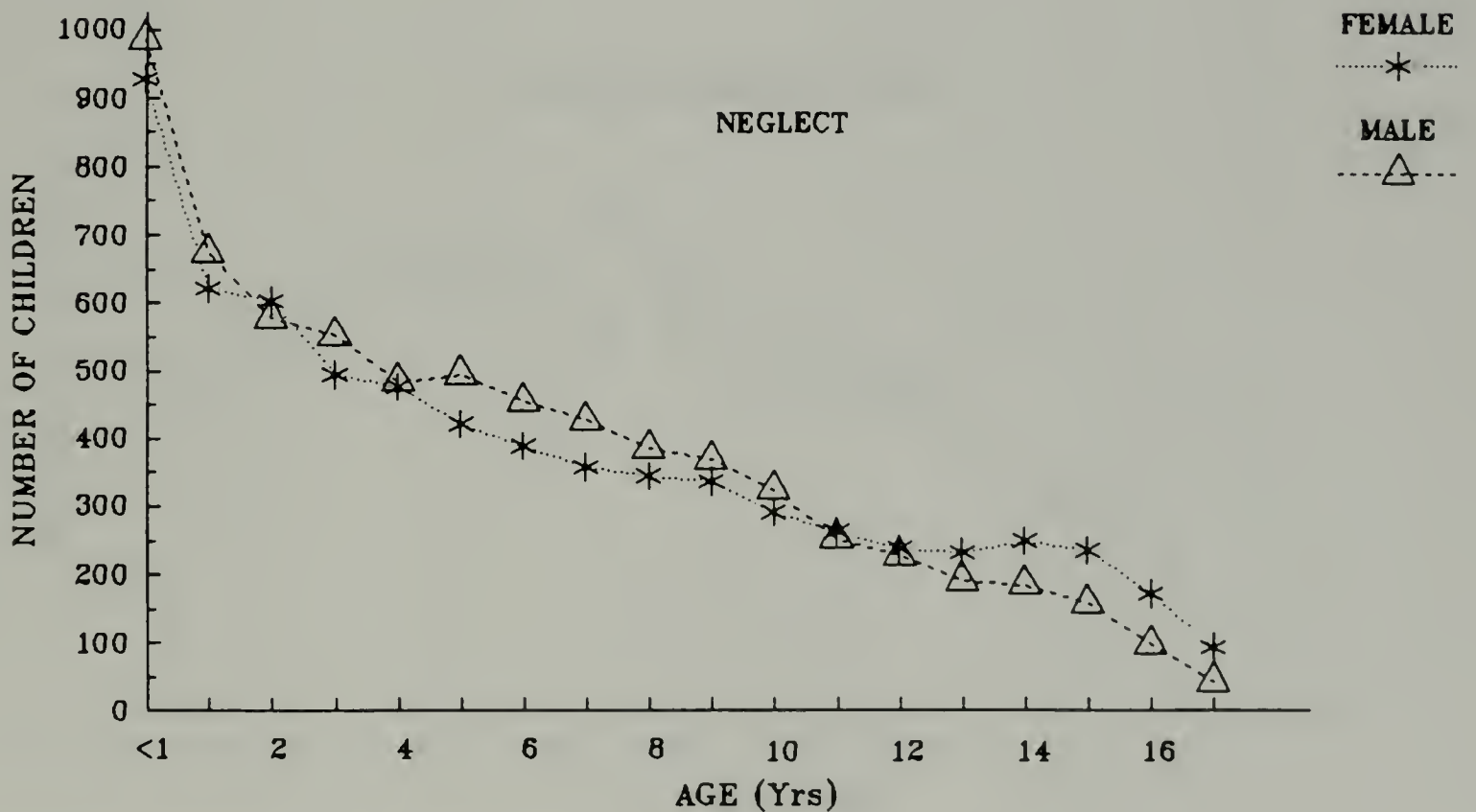
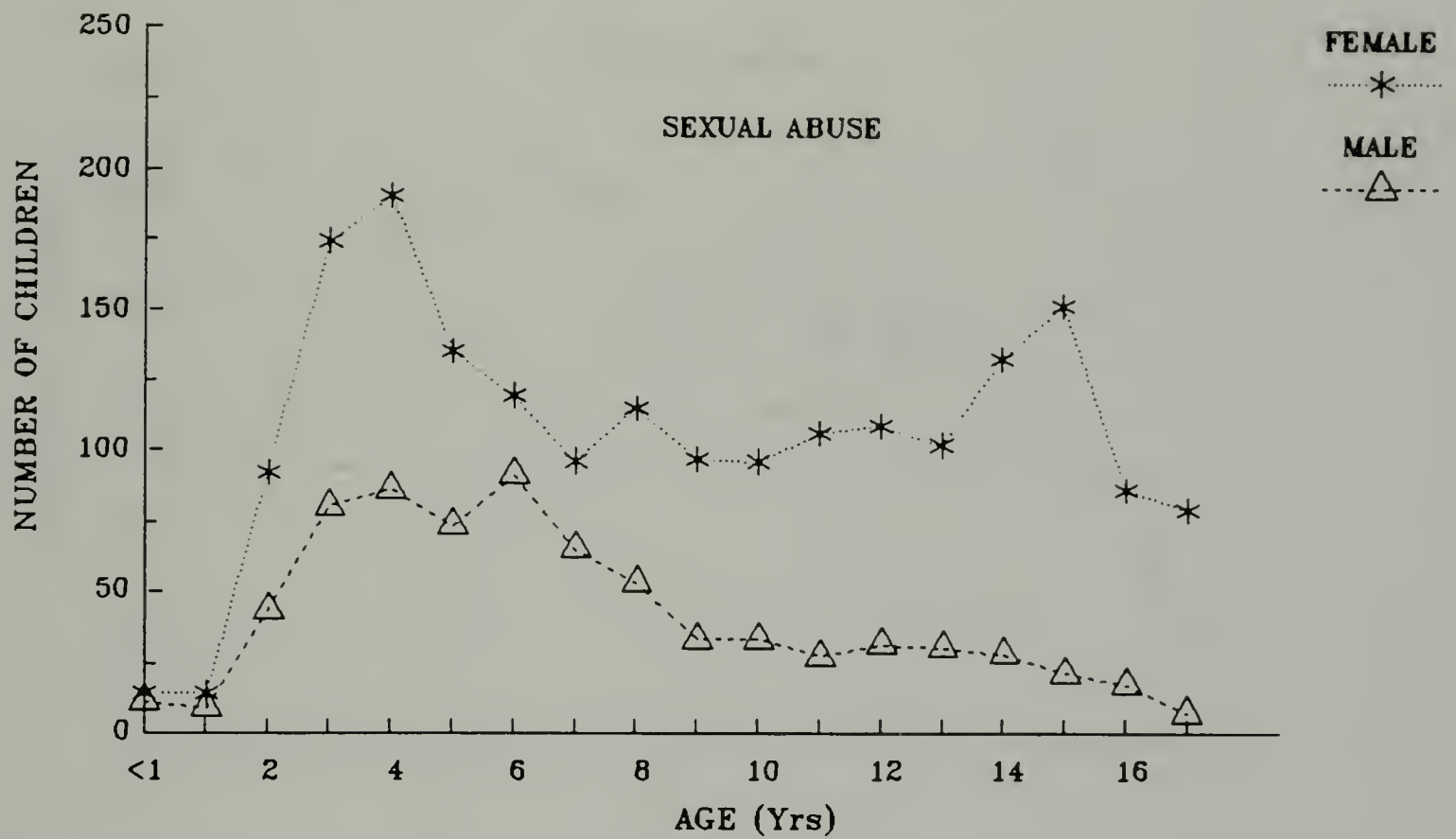
(1) Children with supported investigations are defined as children whose investigation resulted in a supported finding of abuse/neglect.

(2) Includes Puerto Rican, Cuban, Mexican, and Other Hispanic.

(3) Does not include people from the Indo-Chinese peninsula.

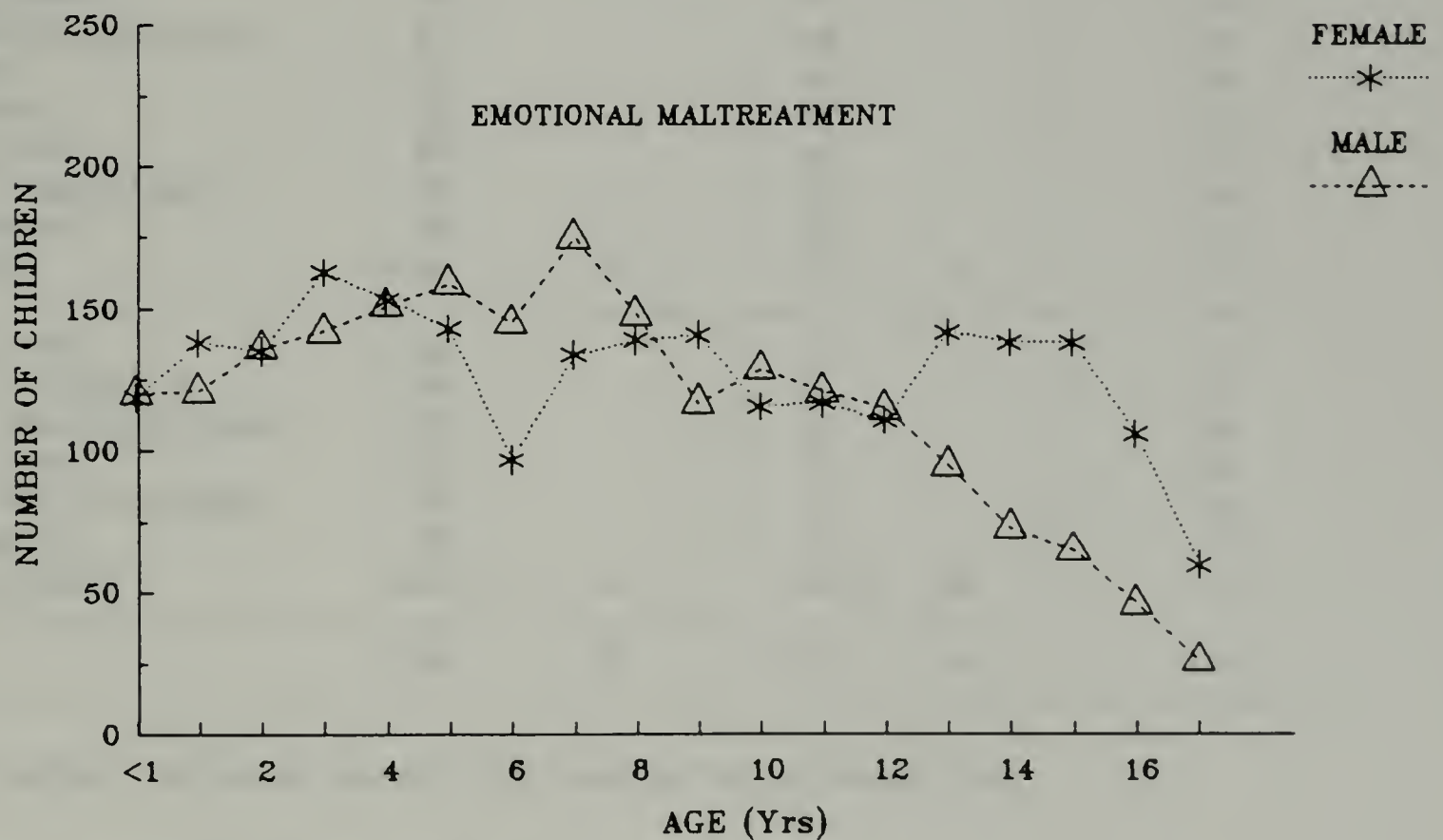
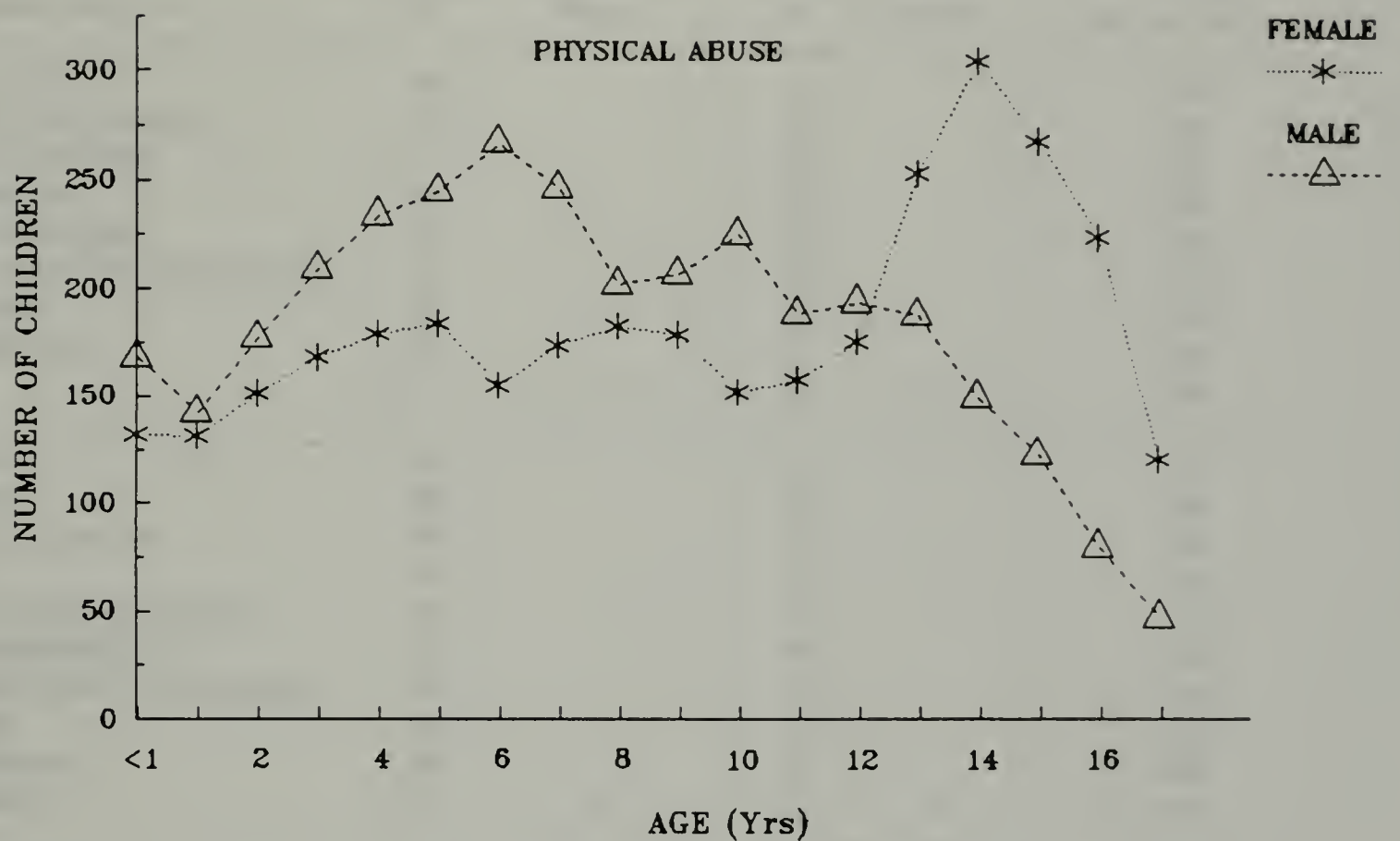
Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

FIGURE 3. AGE AND SEX OF CHILDREN WITH
SUPPORTED INVESTIGATIONS
JANUARY 1 - DECEMBER 31, 1989



Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
Source: ASSIST Extract Tapes (Run-Date 1/16/90)

FIGURE 4. AGE AND SEX OF CHILDREN WITH
SUPPORTED INVESTIGATIONS
JANUARY 1 - DECEMBER 31, 1989



Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
Source: ASSIST Extract Tapes (Run-Date 1/16/90)

Table 9. Children with Supported Investigations of All Maltreatment and Sexual Abuse during
January 1 - December 31, 1989 by Geographic Location.

Children with Supported Investigations					
Geographic Location	All Maltreatment No.	% Change 1988-89	Sexual Abuse No.	% Change 1988-89	Sexual Abuse as % of All Maltreatment
Pittsfield	504		66		13%
Greenfield/Northampton	479		89		19%
Holyoke/Westfield	1,179		114		10%
Springfield	961		102		11%
Fitchburg/Gardner	686		150		22%
South Central/Blackstone Valley	816		182		22%
Worcester	864		129		15%
PAS Agencies	927		132		14%
WEST	6,416	20%	964	15%	15%
Lowell	981		86		9%
Lawrence	660		40		6%
Haverhill/Cape Ann	642		74		12%
Lynn	734		53		7%
Eastern Middlesex/Tri-City	463		77		17%
Framingham/Marlboro	615		80		13%
Cambridge-Somerville/Arlington	668		75		11%
Waltham	295		39		13%
PAS Agencies	875		86		10%
NORTHEAST	5,933	26%	610	5%	10%
Quincy/Weymouth	490		70		14%
Attleboro/Taunton/Worwood	831		104		13%
Brockton	1,154		144		12%
Fall River	736		100		14%
New Bedford	968		168		17%
Cape & Islands/Plymouth	716		131		18%
PAS Agencies	554		76		14%
SOUTHEAST	5,449	23%	793	9%	15%
Morton Street	1,018		55		5%
Dimock Street/Allston	926		63		7%
S.C.F. Mental Health Center	1,062		42		4%
Fields Corner	891		61		7%
Harbor/Charlestown/Chelsea	804		82		10%
PAS Agencies	506		33		7%
BOSTON/BROOKLINE	5,292 (*)	17%	340 (*)	-17%	6%
STATE	23,090	21%	2,707	6%	12%

(*) = Includes investigations completed by the Boston Hot-line and Homeless Units.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

Table 10. Children with Supported Investigations of All Maltreatment and Neglect during
January 1 - December 31, 1989 by Geographic Location.

Children with Supported Investigations			
Geographic Location	All Maltreatment No.	Neglect No.	Neglect as % of All Maltreatment
Pittsfield	504	280	56%
Greenfield/Northampton	479	226	47%
Holyoke/Westfield	1,179	713	60%
Springfield	961	644	67%
Fitchburg/Gardner	686	270	39%
South Central/Blackstone Valley	816	430	53%
Worcester	864	457	53%
PAS Agencies	927	577	62%
WEST	6,416	3,597	56%
Lowell	981	678	69%
Lawrence	660	452	68%
Haverhill/Cape Ann	642	376	59%
Lynn	734	522	71%
Eastern Middlesex/Tri-City	463	219	47%
Framingham/Marlboro	615	329	53%
Cambridge-Somerville/Arlington	668	293	44%
Waltham	295	163	55%
PAS Agencies	875	545	62%
NORTHEAST	5,933	3,577	60%
Quincy/Weymouth	490	241	49%
Attleboro/Taunton/Norwood	831	448	54%
Brockton	1,154	740	64%
Fall River	736	476	65%
New Bedford	968	526	54%
Cape & Islands/Plymouth	716	388	54%
PAS Agencies	554	329	59%
SOUTHEAST	5,449	3,148	58%
Morton Street	1,018	668	66%
Dimock Street/Allston	926	675	73%
S.C.F. Mental Health Center	1,062	821	77%
Fields Corner	891	619	69%
Harbor/Charlestown/Chelsea	804	523	65%
PAS Agencies	506	359	71%
BOSTON/BROOKLINE	5,292 (*)	3,726 (*)	70%
STATE	23,090	14,048	61%

(*) = Includes investigations completed by the Boston Hot-line and Homeless Units.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date 1/19/89).

Table 11. Children with Supported Investigations of All Maltreatment and Physical Abuse during January 1 - December 31, 1989 by Geographic Location.

Children with Supported Investigations			
Geographic Location	All Maltreatment No.	Physical Abuse No.	Physical Abuse as % of All Maltreatment
Pittsfield	504	139	28%
Greenfield/Northampton	479	162	34%
Holyoke/Westfield	1,179	474	40%
Springfield	961	267	28%
Fitchburg/Gardner	686	293	43%
South Central/Blackstone Valley	816	251	31%
Worcester	864	264	31%
PAS Agencies	927	303	33%
WEST	6,416	2,153	34%
Lowell	981	239	24%
Lawrence	660	194	29%
Haverhill/Cape Ann	642	186	29%
Lynn	734	184	25%
Eastern Middlesex/Tri-City	463	163	35%
Framingham/Marlboro	615	173	28%
Cambridge-Somerville/Arlington	668	172	26%
Waltham	295	78	26%
PAS Agencies	875	269	31%
NORTHEAST	5,933	1,658	28%
Quincy/Weymouth	490	117	24%
Attleboro/Taunton/Worwood	831	218	26%
Brockton	1,154	342	30%
Fall River	736	213	29%
New Bedford	968	318	33%
Cape & Islands/Plymouth	716	247	34%
PAS Agencies	554	169	31%
SOUTHEAST	5,449	1,624	30%
Morton Street	1,018	305	30%
Dimock Street/Allston	926	246	27%
S.C.F. Mental Health Center	1,062	236	22%
Fields Corner	891	197	22%
Harbor/Charlestown/Chelsea	804	188	23%
PAS Agencies	506	145	29%
BOSTON/BROOKLINE	5,292 (*)	1,333 (*)	25%
STATE	23,090	6,768	29%

(*) = Includes investigations completed by the Boston Hot-line and Homeless Units.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

Table 12. Children with Supported Investigations of All Maltreatment and Emotional Maltreatment during January 1 - December 31, 1989 by Geographic Location.

Children with Supported Investigations			
Geographic Location	All Maltreatment No.	Emotional Maltreatment No.	Emotional Maltreatment as % of All Maltreatment
Pittsfield	504	118	23%
Greenfield/Northampton	479	130	27%
Holyoke/Westfield	1,179	153	13%
Springfield	961	74	8%
Fitchburg/Gardner	686	74	11%
South Central/Blackstone Valley	816	218	27%
Worcester	864	150	17%
PAS Agencies	927	154	17%
WEST	6,416	1,071	17%
Lowell	981	249	25%
Lawrence	660	114	17%
Haverhill/Cape Ann	642	141	22%
Lynn	734	111	15%
Eastern Middlesex/Tri-City	463	85	18%
Framingham/Marlboro	615	147	24%
Cambridge-Somerville/Arlington	668	262	39%
Waltham	295	72	24%
PAS Agencies	875	202	23%
NORTHEAST	5,933	1,383	23%
Quincy/Weymouth	490	183	37%
Attleboro/Taunton/Norwood	831	210	25%
Brockton	1,154	388	34%
Fall River	736	68	9%
New Bedford	968	117	12%
Cape & Islands/Plymouth	716	112	16%
PAS Agencies	554	135	24%
SOUTHEAST	5,449	1,213	22%
Morton Street	1,018	153	15%
Dimock Street/Allston	926	176	19%
S.C.F. Mental Health Center	1,062	108	10%
Fields Corner	891	175	20%
Harbor/Charlestown/Chelsea	804	139	17%
PAS Agencies	506	79	16%
BOSTON/BROOKLINE	5,292 (*)	839 (*)	16%
STATE	23,090	4,506	20%

(*) = Includes investigations completed by the Boston Hot-line and Homeless Units.

Research, Evaluation, and Planning Unit
 Massachusetts Department of Social Services
 SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

V. TRENDS IN CHILD MALTREATMENT STATISTICS (1983 TO 1989)

Child Maltreatment

From 1983 to 1984, the numbers of reported and investigated children, and children with supported investigations rose by 28%, 31%, and 32%, respectively (Table 1). Successively lower annual increases gradually turned into declines in 1987. This trend ended in 1988 as the numbers of reported, investigated, and supported children increased by 17%, 10%, and 9%, respectively. In 1989, these counts continued to climb (Table 1). The most significant rise was in the number of children with investigations that resulted in a supported finding of maltreatment (19%). Increases for reported and investigated children were 15% and 14%, respectively.

Several factors may have contributed to the resurgence in reported and confirmed child maltreatment. The first is the widespread use of drugs, especially cocaine and crack. National studies have shown that substance abuse is a significant problem in all communities throughout the country. In Massachusetts, a recent DSS study revealed a high association between substance abuse and child maltreatment.⁹ The most frequently used substances were found to be cocaine and alcohol. Of the two, cocaine was more strongly related to severe neglect. Alcohol was more highly correlated with physical abuse.

⁹ Herskowitz, J., M. Seck, and C. Fogg. 1989. Substance abuse and family violence: Part I. Identification of drug and alcohol usage during child abuse investigations in Boston. Research, Evaluation, and Planning Unit, Mass. Dept. Social Services.

Herskowitz, J. and M. Seck. 1990. Substance abuse and family violence: Part II. Identification of drug and alcohol usage in child abuse cases in Massachusetts. Research, Evaluation, and Planning Unit, Mass. Dept. Social Services.

A quantitative indicator of increased substance abuse in Massachusetts is the annual count of children with supported findings of congenital drug (primarily heroin and methadone) addiction:

Congenital Drug Addiction

<u>Year</u>	<u>Children with Supported Investigations</u>	<u>% Annual Change</u>
1984	82	---
1985	105	+28%
1986	140	+33%
1987	189	+35%
1988	288	+52%
1989	353	+23%

This increase in children with supported investigations of congenital drug addiction may not only reflect an increase in reports because of greater reporter awareness, but may also indicate a real increase in drug use by pregnant women.

Another possible reason for the increase in reports of child maltreatment is the training conducted by DSS in 1988 and 1989 for law enforcement and school personnel, private social service and day-care staff, and medical examiners. During the training sessions, these mandated reporters were provided with information on the child abuse reporting law and the DSS activities related to investigations and service delivery.

Intensive media coverage of numerous incidents of severe child maltreatment throughout the country has further sensitized the general public. This increased awareness has undoubtedly contributed to the rise in child maltreatment reports from nonmandated and mandated sources. In Massachusetts, there have been a number of especially violent child abuse cases reported by the news media over the past two years.

A significant rise in child maltreatment reporting is expected during 1990. The contributing factors mentioned above will be supplemented by the impact of DSS Project Protect.¹⁰ This program was prompted by the dramatic increase in the incidence of substance abuse and family violence in the DSS caseload and the confirmation that both substance abuse and

¹⁰ Massachusetts Dept. of Social Services. 1990. Project Protect, Guidelines for Protecting Children in Substance Abusing and Violent Families. Case Practice and Policy Manual. p.160a-160j

adult domestic violence are directly related to child maltreatment. Implemented in January, 1990, Project Protect is expected to result in increased reporting of all forms of child maltreatment.

Sexual Abuse

The substantial growth in the number of children with supported investigations during 1984 and 1985 (see table below) can be attributed to heightened professional and public awareness of the problem of sexual abuse. Following this peak period of reporting, the annual count of sexually abused children declined before stabilizing in 1988. In 1989, the number of children with supported investigations of sexual abuse rose by 6%. It is not known to what extent the previously mentioned factors (substance abuse and the overall increase in reporting) have influenced this rise in sexual abuse.

Sexual Abuse

<u>Year</u>	<u>Children with Supported Investigations</u>	<u>% Annual Change</u>
1983	1386	---
1984	2826	+104%
1985	3533	+25%
1986	2965	-16%
1987	2554	-14%
1988	2557	less than 1%
1989	2707	+6%

VI. APPENDIX

APPENDIX

Table A. Duplicated and Unduplicated Counts of Reports and Supported Investigations by Type of Maltreatment during January 1 - December 31, 1989. (1)

Counts	Type of Maltreatment						
	All Maltreatment (2)	Sexual Abuse	Neglect	Physical Abuse	Emotional Maltreatment	Congenital Drug Addiction	Failure to Thrive
Duplicated Counts:							
Children Reported	70,713	7,184	38,010	18,873	9,333	486	162
Reports	45,717	5,714	22,382	13,218	5,501	419	110
Children per Report (3)	1.5	1.3	1.7	1.4	1.7	1.2	1.5
Unduplicated Counts:							
Children Reported	49,661	6,231	28,604	16,102	8,400	479	155
Families Reported	30,759	4,799	16,546	10,906	4,954	412	104
Duplicated Counts:							
Children w/Supported Investigations:	22,532	2,707	14,048	6,768	4,506	353	39
Supported Investigations	14,838	2,263	8,303	4,841	2,632	328	33
Children per Supported Investigation (4)	1.5	1.2	1.7	1.4	1.7	1.1	1.2
Unduplicated Counts:							
Children w/Supported Investigations	20,458	2,598	12,935	6,475	4,378	353	39
Families w/Supported Investigations	13,068	2,158	7,527	4,560	2,562	327	33

(1) Duplicated means that a child is counted each time he/she is reported and investigated, whereas with unduplicated counts, a child is counted only once, regardless of the number of times reported and investigated during the year.

(2) Total counts do not equal the summation of specific maltreatments because a child (and family) may have been reported or supported for more than one type of maltreatment.

(3) Children per report equals the duplicated count of children reported divided by the number of reports.

(4) Children per supported investigation equals the duplicated count of children with supported investigations divided by the number of supported investigations.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).
ASSIST Report NTDSS742A, "Monthly Report and Investigation Activity."

APPENDIX

Table B. Unduplicated Counts of Children Reported for All Maltreatment and Sexual Abuse by County during January 1 - December 31, 1989. (1)

County (2)	All Maltreatment		Sexual Abuse	
	Children Reported No.	Reporting Rate (3) (per 10,000)	Children Reported No.	Reporting Rate (3) (per 10,000)
Suffolk	7,809	500	713	46
Middlesex	6,764	209	863	27
Essex	5,479	330	580	35
Worcester	5,455	297	879	48
Hampden	4,807	407	606	51
Bristol	4,451	330	710	53
Plymouth	3,600	263	535	39
Norfolk	2,239	159	345	24
Berkshire	1,571	453	187	54
Barnstable	1,102	264	163	39
Hampshire	859	228	136	36
Franklin	841	505	132	79
Dukes	59	218	13	48
Nantucket	28	232	8	66
Unspecified/Unknown	2,579	----	300	--
Out of State/Country	334	----	61	--
TOTAL	47,977	321	6,231	42

(1) For all maltreatment and sexual abuse, a child is counted only once, regardless of the number of times reported in 1989.

(2) Residence of maltreated children.

(3) Number of children reported per 10,000 children up to 19 years old.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services
SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

APPENDIX

Table C. Unduplicated Counts of Children Reported for Neglect, Physical Abuse, and Emotional Maltreatment by County during January 1 - December 31, 1989. (1)

County (2)	Neglect		Physical Abuse		Emotional Maltreatment	
	Reported No.	Reporting Rate (3) (per 10,000)	Reported No.	Reporting Rate (3) (per 10,000)	Reported No.	Reporting Rate (3) (per 10,000)
Suffolk	5,629	360	2,443	156	1,193	76
Middlesex	3,991	123	2,465	76	1,529	47
Essex	3,355	202	1,722	104	806	49
Worcester	3,220	175	2,152	117	1,096	60
Hampden	2,433	206	1,554	132	471	40
Bristol	2,856	212	1,690	125	769	57
Plymouth	2,292	167	1,227	90	961	70
Norfolk	1,329	94	728	52	640	45
Berkshire	688	198	429	124	245	71
Barnstable	616	148	425	102	90	22
Hampshire	346	92	242	64	114	30
Franklin	332	199	242	145	171	103
Dukes	25	92	23	85	6	22
Nantucket	14	116	12	100	3	25
Unspecified/Unknown	1,300	----	634	--	247	----
Out of State/Country	178	----	114	--	59	----
TOTAL	28,604	191	16,102	108	8,400	56

(1) For neglect, physical abuse, and emotional maltreatment, a child is counted only once, regardless of the number of times reported in 1989.

(2) Residence of maltreated children.

(3) Number of children reported per 10,000 children up to 19 years old.

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

APPENDIX

Table D. Unduplicated Counts of Children Reported for All Maltreatment and Sexual Abuse by City and Town during January 1 - December 31, 1989. (1)

City (2)	All Maltreatment		Sexual Abuse	
	Children Reported	Reporting Rate (3)	Children Reported	Reporting Rate (3)
	No.	(per 10,000)	No.	(per 10,000)
Boston	6,991	501	653	47
Worcester	1,886	448	253	60
Springfield	1,791	399	212	47
Brockton	1,694	541	257	82
Lowell	1,499	589	140	55
New Bedford	1,434	532	218	81
Lynn	1,396	696	139	69
Lawrence	1,259	634	99	50
Fall River	1,115	454	170	69
Holyoke	1,080	848	139	109
Pittsfield	677	537	73	58
Chicopee	637	493	64	50
Taunton	568	458	66	53
Cambridge	523	277	77	41
Fitchburg	522	475	79	72
Haverhill	498	396	55	44
Quincy	490	299	57	35
Malden	473	414	57	50
Somerville	451	289	44	28
Chelsea	418	637	32	49
Westfield	392	410	53	55
Framingham	375	250	36	24
Attleboro	358	369	45	46
Salem	330	380	48	55
Revere	324	449	23	32
North Adams	320	762	44	105
Greenfield	313	688	47	103
Waltham	310	258	33	27
Weymouth	303	234	51	39

(1) For all maltreatment and sexual abuse, a child is counted only once, regardless of the number of times reported in 1989.

(2) Selected only those cities or towns in Massachusetts which had 300 (unduplicated) or more children in residence who were reported for maltreatment.

(3) Number of children reported per 10,000 children up to 19 years old.

Research, Evaluation, and Planning Unit

Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

Table E. Unduplicated Counts of Children Reported for Neglect, Physical Abuse, and Emotional Maltreatment by City and Town during January 1 - December 31, 1989. (1)

Counts of Children						
City (2)	Neglect		Physical Abuse		Emotional Maltreatment	
	Reported	Reporting Rate (3)	Reported	Reporting Rate (3)	Reported	Reporting Rate (3)
	No.	No.	No.	No.	No.	No.
Boston	5,143	369	2,168	155	1,099	79
Worcester	1,196	284	772	183	363	86
Springfield	895	199	565	126	127	28
Brockton	1,181	377	553	177	476	152
Lowell	1,044	411	501	197	300	118
New Bedford	986	366	529	196	246	91
Lynn	1,001	499	411	205	163	81
Lawrence	877	441	415	209	156	79
Fall River	721	293	469	191	104	42
Holyoke	445	349	306	240	79	62
Pittsfield	309	245	155	123	110	87
Chicopee	262	203	194	150	42	33
Taunton	377	304	190	153	137	111
Cambridge	293	155	185	98	121	64
Fitchburg	295	268	188	171	29	26
Haverhill	185	147	122	97	62	49
Quincy	301	184	136	83	192	117
Malden	328	287	182	159	80	70
Somerville	258	165	166	106	103	66
Chelsea	268	409	139	212	39	59
Westfield	276	289	177	185	90	94
Framingham	187	125	123	82	63	42
Attleboro	219	226	141	145	86	89
Salem	210	242	106	122	71	82
Revere	175	243	115	159	43	60
North Adams	139	331	105	250	56	133
Greenfield	137	301	100	220	53	117
Waltham	190	158	117	97	84	70
Weymouth	186	144	94	73	95	73

(1) For neglect, physical abuse, and emotional maltreatment, a child is counted only once, regardless of the number of times reported in 1989.

(2) Selected only those cities or towns in Massachusetts which had 300 (unduplicated) or more children in residence who were reported for maltreatment.

(3) Number of children reported per 10,000 children up to 19 years old.

Research, Evaluation, and Planning Unit
Massachusetts Department of Social Services

SOURCE: ASSIST Extract Tapes (Run-Date: January 16, 1990).

FFY'91

IV-B PLAN

CHAPTER IV

STATUS OF FFY'90 GOALS

FUTURE GOALS DEVELOPMENT

PRIORITY I

THE PROTECTION OF CHILDREN
AT RISK OF ABUSE OR NEGLECT

GOAL 1: TO ENSURE CONSISTENT PROVISION OF PROTECTIVE SERVICES
STATEWIDE WITHIN MANDATED TIMEFRAMES

In addition to regular monitoring through monthly management reports and followup with the Field Support Directors, the Deputy Commissioner's Office included focus on protective practice in the completion of Area Monitoring during FY'90. Record reviews of about thirty-five records per site and interviews of staff at all levels have been conducted at each DSS site. Specifically regarding protective practice, the record review included one full page analysis of the most recent 51A & B, if any, in each record. Timeliness of completion of both emergency and non-emergency investigations was examined as was compliance with the Department's policy that investigations begin within two days of the receipt of a non-emergency report. Despite steadily increasing numbers of reports throughout FY'90, the Department has consistently provided protective services statewide within mandated timeframes.

Quality as well as timeliness was addressed in both the record reviews and the interviews with protective intake staff - supervisors, screeners and investigators. For example, the record review asked whether the investigator had made collateral contacts and had evaluated risk factors during the investigation. Then, in the interview, staff were asked to describe the types of collateral contacts which they usually made and the risk factors which they considered most important. The reports and responses

GOAL 1: TO ENSURE CONSISTENT PROVISION OF PROTECTIVE SERVICES
STATEWIDE WITHIN MANDATED TIMEFRAMES (cont'd)

revealed the depth of experience and expertise in the protective intake units across the state.

Following each site visit, a monitoring report has been produced and shared with the Area Director and the Field Support Director. Each report details the structure and the performance of the office and specific recommendations for improvement, if needed. Also, the Deputy's Office has involved other Central Office Units, for example, the Training Unit, to provide immediate assistance as well as to plan to meet long-term training needs. The investigation training has been particularly useful to protective intake staff, even those with much experience, who cited the investigation training as refreshing and refocusing them. In response to the monitoring report, the Area Director and the Field Support Director follow-up the recommendations and provide a written response to the Deputy Commissioner.

During FY'90, the number of child abuse and neglect reports continued to increase with a 14% rise in reports over FY'89, which had experienced a 14% rise over FY'88. An all-time high of 4958 reports were received in May 1990 with much of the reported abuse and neglect directly related to domestic violence and substance abuse. The Department is addressing these issues through Project Protect, which includes developing closer working rela-

GOAL 1: TO ENSURE CONSISTENT PROVISION OF PROTECTIVE SERVICES
STATEWIDE WITHIN MANDATED TIMEFRAMES (cont'd)

tionships with the criminal justice system, requiring drug or alcohol treatment for addicted parents and emphasizing the extent of the problem and the effect upon children in expanded training in both domestic violence and substance abuse for field staff. Guidelines for Project Protect were distributed to field staff throughout FY'90.

During FY'91, several steps will be taken to improve the quality and timeliness of investigations.

1. The Area Office monitoring process will be revised. There will be one initial report, with specific recommendations for follow-up. The monitoring team will then do one or a series of follow up visits to each area on specific issues cited in the report.
2. As a result of a report issued by the research and evaluation unit at DSS, a number of qualitative concerns have been raised regarding the investigation process. These include:
 - a. increasing the number of reported children interviewed and seen by investigators;
 - b. increasing the number of non-reported children viewed and interviewed;
 - c. increasing the number of collateral contacts made;
 - d. increase the number and quality of administrative reviews.

The areas are each developing plans to address these concerns. In addition, each Field Support Office is intensifying and increasing the amount of training for investigators.

Project Protect will include working closely with parole boards and probation officers to increase cooperation in protecting children.

GOAL 2: TO CONTINUE TO IMPROVE THE WORKING RELATIONSHIPS BETWEEN THE DEPARTMENT AND DISTRICT ATTORNEYS UNDER CHAPTER 288

The Department of Social Services is mandated by law to notify and provide information to the appropriate District Attorney if certain specific conditions have resulted from abuse or neglect. The Department is also permitted to notify and provide information about other possible criminal conduct to the appropriate District Attorney.

In FY'90, the Department and District Attorneys' offices continued to collaborate on the most serious cases of child physical and/or sexual abuse; over 2,700 cases were referred during FY90. Many of those cases involved issues related to domestic violence and substance abuse. Prior to this past year there was no systematic means of determining what happened to referrals made to the DA's. The Department is now tracking the DA referrals through the criminal justice system by requesting ongoing information from the DA's on case processing. To address the problem of families affected by violence and substance abuse, the Department implemented Project Protect in January 1990 which included Case Practice Policy and Procedure Guidelines to assist social workers in working with these families. The guidelines require the Department to work more closely with law enforcement agencies. These guidelines are being evaluated to determine, among other

GOAL 2: TO CONTINUE TO IMPROVE THE WORKING RELATIONSHIPS BETWEEN
THE DEPARTMENT AND DISTRICT ATTORNEYS UNDER CHAPTER 288
(cont'd)

things, the impact of increased collaboration with law enforcement. Based on the findings of the evaluation, the Guidelines will be further revised and the revisions implemented in FY91.

House Bill #5677: An Act Requiring the Department of Social Services to notify local law enforcement agencies in certain circumstances was passed and implemented in February, 1990. The Department has begun to notify local law enforcement agencies, as well as the District Attorney, of certain cases. In anticipation of this, the Department communicated with the law enforcement agencies and established police liaisons within each DSS office.

The Department continued to support the passage of S-605, "An Act Further Regulating the Reporting and Investigation of Certain Cases of Child Abuse" but the bill died at the end of the legislative session. The bill has been reintroduced this year (as H-2489) and the Department will continue to work for its passage. The bill would enhance the District Attorney Reporting Law by directing referrals to the District Attorney with jurisdiction for the incident and by allowing multi-disciplinary teams to be convened during the Department's investigative process. During FY90, training sessions were held with probation officers to familiarize them with the Department of Social

GOAL 2: TO CONTINUE TO IMPROVE THE WORKING RELATIONSHIPS BETWEEN
THE DEPARTMENT AND DISTRICT ATTORNEYS UNDER CHAPTER 288
(cont'd)

Services activities and procedures. Additional trainings are planned for FY91 for police officers, and parole and probation officers.

Central office staff will continue to provide technical assistance to Area and Regional Staff as needed in this regard.

GOAL 3: TO PROTECT CHILDREN AT RISK OF, OR VICTIMS OF, SEXUAL ABUSE

Substantiated sexual abuse increased dramatically in Massachusetts between 1983 and 1985 (1,386 substantiations to 3,533). In response to these increases, the Department implemented substantial preventive efforts and increased diagnosis and treatment capacity. From 1985 to 1988, children with substantiated investigations for sexual abuse leveled off, but increased again in 1989. They rose from 2,557 in 1988 to 2,707 children with substantiated investigations of sexual abuse in 1989, a 6% increase.

Increased diagnostic capacity has been achieved by use of medical and mental health consultants during the abuse investigation process, special training for DSS social workers, and the use of Sexual Abuse Intervention Network (SAIN) teams that include DSS social workers, police and District Attorney staff, and mental health professionals.

Acknowledging that sexual abuse is not unique to a specific group or type of individual, the Department makes a wide variety of treatment resources available. These programs include specialized counseling services and therapy groups for victims, parents of victims, and perpetrators. To evaluate the effectiveness of these various treatment modalities as well as the management of these cases, the Department has completed a Sexual Abuse Treatment Outcomes Research Project (SATP), funded through a Federal grant from NCCAN. Begun in January, 1986, the SATP was concluded in May, 1989. The four-part final

GOAL 3: TO PROTECT CHILDREN AT RISK OF, OR VICTIMS OF, SEXUAL ABUSE (cont'd)

includes:

1) a description of the service system, 2) a descriptive analysis of the sexually abused population and their families, 3) an evaluation of DSS case management of the study population and 4) an evaluation of the treatment process.

As an additional component of this research grant, the Massachusetts Society for the Prevention of Cruelty to Children has evaluated its treatment programs for sexual offenders. This additional research has affirmed the value of therapeutic group treatment for offenders at least in the short-term. Longer term follow-up (2 years) is continuing.

Continuing goals for the FY 1990 to 1993 period include maintenance of social worker training initiatives and therapeutic services contracts, expansion of the use of SAIN teams to those regions of the state where they are not yet available, and continuing improvements in the Department's coordination with the District Attorneys across the state.

An evaluation of SAIN team effectiveness is planned for FY'91 pending approval of funding. Under MGL Chapter 288, all substantiated sexual abuse reports have been referred to the local District Attorneys since 1983. Recent improvements to the Department's on-line computer system (ASSIST) have included entry of DA referral information.

GOAL 3: TO PROTECT CHILDREN AT RISK OF, OR VICTIMS OF, SEXUAL ABUSE (cont'd)

Further improvements in DSS-DA information flow are planned for FY'91 and beyond.

PRIORITY II

TO PROVIDE HIGH QUALITY SERVICES TO CHILDREN IN SUBSTITUTE
CARE AND PROMOTE PERMANENCY PLANNING

GOAL 4: TO ASSURE THE APPROPRIATE PLACEMENT OF EACH CHILD

It is the policy of the Department to support and strengthen families, and to help parents maintain primary responsibility for their children. Therefore, the Department makes reasonable efforts to encourage and assist families to make use of their own resources, as well as community, other state agency, and DSS resources, to prevent the placement of their children outside of their home.

In FY'90, over 24,950 families, with nearly 45,400 children, were open for DSS services at any given time. The majority of these children (approximately 75%) remained at home while receiving DSS services.

When placement is necessary, as it was for approximately 24% of the children in FY'90, the social worker's goal is to place the child in the least restrictive setting possible and in the closest possible proximity to the child's family to promote the opportunity for visits, and to allow the child to continue in his/her current school program.

From the time a child is placed, a plan is developed for returning the child home or, if that is not possible, for identifying an alternative permanent home. The plan also includes services to meet the needs of the child and tasks for all parties to the plan. The plan is reviewed every six months, during the foster care review conference.

GOAL 4: TO ENSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

During FY'90, as part of its continuing commitment to utilize Intensive Home Based Services in placement prevention, treatment and family reunification, the Department developed 20 new intensive family intervention based programs through its partnership and other private agencies statewide. Each of the new programs are modeled after the Department's highly successful Family Life Center, now one and one-half years in operation.

The Department also began planning a new alternative to traditional out of home foster care. The "Parenting Partners Program" will allow "part-time" foster parents to provide intensive in-home professional assistance to families in crisis to help restore family functioning and to avert the need for the removal of children. "Parent Partners" will teach parenting skills; provide in-home support to reduce mother's sense of isolation; provide assistance and advocacy to help the mother in locating better housing; and provide respite care to help avert family crises. It is expected that this program will be piloted in FY'91.

For those children whose need for residential treatment is due to special needs, and whose parents are able and willing to maintain care and custody and to be full partners in the program. The "Special Needs Parenting Partnership Program" allows families to receive residential services through the Department without giving up care or custody thus promoting family integrity and independence.

GOAL 4: TO ENSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

During FY'90, the Department increased its capacity to place children in the most appropriate settings by presenting several special topic-intensive foster family recruitment campaigns. One such campaign included public service announcements, press releases, radio and television coverage, direct mail and special incentives for foster families participating in outreach. The campaign yielded 150 new foster families.

The Department continues to be greatly impacted by increased drug and alcohol use among families. The effects are seen in the number of children reported abused and neglected, children neglected because of parental drug abuse, children with AIDS, children under age five in foster care, and infant deaths. During FY'90 there were 70,713 children reported abused or neglected representing a 15% increase over FY'89.

During FY'90 the Department conducted a study revealing substance abuse as a concurrent factor in 59% of all supported investigations of physical abuse, neglect and emotional maltreatment statewide (Reference "Identification of Drug and Alcohol Usage During Child Abuse Investigations in Massachusetts"). In the Boston area, 89% of all of the supported reports of child abuse or neglect involving children under one year old were in families where one or more members were identified as substance abusers during investigations: 68% were hospital

GOAL 4: TO ENSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

reports of newborns with congenital drug addiction, positive toxic screens for cocaine, or fetal alcohol syndrome. Estimates are that 5000 drug affected babies are born yearly in Massachusetts.

In response, the Department has designed a multifaceted approach call Project Protect to better understand and provide services to children where substance abuse and/or domestic violence contribute to an unstable family environment causing harm or risk. Project Protect's objectives are to protect children; to assist substance abusing parents through direct interventions; to assist social work staff through clarification of case practice expectations; to develop resources to better meet the general needs of children and adults; and to provide information to the general public about the complex issues contributing to these dangerous situations. Project Protect has focused the Department's energies in protecting children from abusing families, in the following ways:

- o The Department has implemented case practice guidelines that:

- require a closer working relationship with the criminal justice system (i.e., law enforcement, both police and district attorneys, probation and the court);
- keep children more visible in the communities by requiring medical screening, use of day care, visiting nurses and frequent home contacts;

GOAL 4: TO ENSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

- support and assist victims of domestic violence, the help of battered women's advocates, to take steps to ensure their own and their children's safety;
 - require as appropriate, participation in drug treatment or drug rehabilitation programs including regular testing or related services;
 - require court action when parents are unable or unwilling to ensure the health and safety of their children.
- o The Family Life Center has developed a two week risk assessment model to quickly determine the severity of risk to children through a clinical team appraisal of factors present in the household. The Center also provides: nursing and pediatric services to screen for physical indicators of risk or harm to children; health questionnaires to engage families by demonstrating concerns for the well being of children, and technical assistance regarding service planning, service provision and safety issues.
- o A battered women's advocate has been hired to work within the Family Life Center to provide information about resources for victims of domestic violence, assist in the filing of 209A restraining orders whenever appropriate, and help with decision making.
- o A substance abuse specialist has been hired by the Family Life Center to provide substance abuse evaluations to DSS clients; offer consultation, referral

GOAL 4: TO ASSURE THE APPROPRIATE PLACEMENT OF EACH CHILD

and training regarding substance abuse issues; and act as the Department's liaison to substance abuse providers across the state.

- o Staff training and staff development opportunities addressing substance abuse and domestic violence have been increased and mandatory participation has been implemented for all levels of Department staff.
- o The Department conducted a statewide community public education campaign to inform the general public about the importance of reporting child abuse and neglect and continues to offer training to professional groups who are mandated reporters. During FY'90, Commissioner Matava also formed the DSS "Drug Council". Members of the Council include the Deputy Commissioner, the Assistant Commissioner for the Office of Professional Services, the Director of the Department's Training Unit, the Director and Clinical Coordinator of the Family Life Center, the Director of Research, Evaluation and Planning, and the Administrator of the Department's Women in Transition Services (battered women's shelters) and Child Care AIDS Network. The Drug Council meets every two weeks to plan ongoing interventions and conduct problem solving at the executive level.

Project Protect is an initial step to increase the safety of children in substance abusing homes. It is very clear

GOAL 4: TO ASSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

however, that additional resources are needed if children are to be free from the dangers of addicted adults. All levels of government must work together to eliminate barriers to services, to improve interagency and inter-departmental coordination, and, to ensure access and availability for mothers and their children to housing, financial assistance, health care and treatment services.

Toward this end, the Department meets regularly with the Executive Office of Human Services (EOHS), the Department of Public Welfare and the Department of Public Health specifically for the purpose of sharing information and collaborating in the development of substance abuse programs and related operations. One outgrowth of this activity has been the initiation of a planning process to develop a number of new treatment shelters capable of meeting the needs of individuals with histories of substance abuse. Each of the participating EOHS agencies will contribute to shelter operations and services. It is expected that at least four treatment shelters will be fully developed during FY'91.

The Commissioner also participates in the Governor's Anti-Crime Council to promote effective working relations with law enforcement and to plan interventions with local police departments. Every DSS Area Office has also appointed a staff person to serve as a DSS liaison with local police departments.

GOAL 4: TO ASSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

The Massachusetts Department of Social Services' specialized foster care program, entitled P.A.C.T. (Parents and Children Together) supports foster parents in their delivery of planned, specialized services to children in foster care. The program provides a structured system for recognizing and reimbursing foster parents for the specialized services/tasks they perform to address the identified needs in a child's service plan. Fundamental to the program is the philosophy of partnership in planning and delivering specialized foster care services.

During FY'90 the number of consumers receiving P.A.C.T. services continued to rise. The Department's P.A.C.T. administrator reported an 18% increase in utilization between January and April 1990 alone. As of April 1990, more than 14% of the children in foster care placement were receiving P.A.C.T. services.

Collaborative efforts among DSS staff and foster parents have enhanced the Department's capacity to deliver quality specialized care to children in substitute care.

Some of the P.A.C.T. services our foster parents continue to provide include:

- o Teaching an adolescent mother the basic skills of parenting.
- o Providing medical support services as directed by a physician (e.g. feeding via a gastro-intestinal tube, administration of oxygen, implementation of range of motion exercises).

GOAL 4: TO ASSURE THE APPROPRIATE PLACEMENT OF EACH CHILD (cont'd)

- o Supervising visitation between foster children and their biological parents and providing documentation of the interaction between the parents and children to the social worker.

The success of the P.A.C.T. Program can be measured by the continued achievement of children's service plan goals, the prevention of disrupted placements, the improvement of a child's physical/emotional functioning, a child's return home to a parent trained by the foster parent to implement the child's medical protocol, etc. With team planning and support, foster parents are now:

- o Better equipped to provide specialized foster care services to children who may have previously been placed in residential or hospital care.
- o Better able to assist adolescents to prepare for independent living.
- o Better prepared to teach adolescent mothers the essentials of caring for a child.
- o Better trained and supported to provide quality care and medical services to our children who are medically fragile, including children with AIDS.

The Department plans to continue its provision of high quality services to children in foster care via the P.A.C.T. Program.

GOAL 5: TO CONTINUE TO WORK WITH THE COURTS TO ENSURE
DISPOSITIONAL HEARINGS FOR CHILDREN IN SUBSTITUTE CARE

During FY '90:

- o The internal computerized tracking system became fully operational in FY '90. Reports are now generated on a monthly basis indicating those cases that are due for a dispositional hearing.
- o The overall raw numbers of dispositional hearings continued to rise in a dramatic fashion.
- o DSS continued to work with DSS managers, and court representatives to address delays and problems that have arisen in implementing the dispositional hearing tracking system. The General Counsel and Deputy Commissioner personally met with numerous District Court Judges across the state to discuss the full implementation of this system.
- o New pleadings were developed to assist DSS lawyers in obtaining timely dispositional hearings. A standardized court report was developed to assist in the conduct of these hearings.
- o A training program for judges concerning clinical issues including permanency planning and "reasonable efforts" determination was held in January 1990. This was a statewide training open to all District, Juvenile and Probate Court judges. It was conducted by a multi-disciplinary group.

During FY '91, the Department plans:

- o The computerized dispositional hearing tracking system will be refined. A component will be added allowing for the aggregate determination of the number of dispositional hearings conducted by each court in the Commonwealth.
- o A judicial training program will be conducted concerning permanency planning and reasonable efforts determination.
- o The various computerized and manual tracking systems developed by the various courts for purposes of scheduling dispositional hearings will be integrated into the system used by DSS for tracking these cases.

GOAL 5: TO CONTINUE TO WORK WITH THE COURTS TO ENSURE
DISPOSITIONAL HEARINGS FOR CHILDREN IN SUBSTITUTE CARE
(cont'd)

- o DSS will fully implement a unified and uniform system to generate the reports that must be filed with each court prior to dispositional hearings.
- o DSS will fully implement a procedure for obtaining timely dispositional hearings in those circumstances when the courts fail to schedule necessary hearings.

During FY '92 and '93, the Department plans:

- o To continue the refinement of the computerized tracking system.
- o To continue appropriate judicial training on the issues of permanency planning.
- o To assist in obtaining increased judicial appointments and court resources to effectuate the ability to provide timely dispositional hearings.

GOAL 6: TO MAINTAIN THE DEVELOPMENT OF SERVICE PLANS AND MONITOR
THE CONDUCTING OF CASE REVIEWS

During FY'90, in an effort to assist field staff in managing increasing complex caseloads, the Deputy Commissioner's Office directed an initiative to reduce, consolidate and simplify the ASSIST reports which track the timely completion of service plans and case reviews. Reports will be issued every month on the same date for investigations, ongoing casework activity and family resource activity. Ongoing workers and family resource workers will be able to see planned activity on their caseload projected over a two-month period. This will especially help workers and supervisors meet the requirements for development of service plans and conduct of case reviews. The Deputy Commissioner's Office will continue to monitor service plans and case reviews through monthly management reports and follow-up with the Field Support Directors.

In addition, as stated under Goal 1, the Deputy Commissioner's Office included focus on on-going casework activities in the completion of Area Monitoring during FY'90. Each of the approximately thirty-five record reviews completed at each site included one section specific to the quality and timeliness of the most recent service plan and another specific to Area-based case reviews as well as to foster care reviews. These sections highlighted family participation, clarity of problem statements, appropriateness of tasks to the service plan goal,

GOAL 6: TO MAINTAIN THE DEVELOPMENT OF SERVICE PLANS AND MONITOR THE CONDUCTING OF CASE REVIEWS (cont'd)

measurable changes needed and tasks agreed upon, and progress toward the service plan goal. In protective cases, the case review was also checked for a statement regarding the level of risk to the child. As stated under Goal 1, a monitoring report has been produced for each site and shared with the Area Director and the Field Support Director, who follow-up any recommendations and provide a written response to the Deputy Commissioner.

As cited in goal 1, the area monitoring process will now include area specific follow-up.

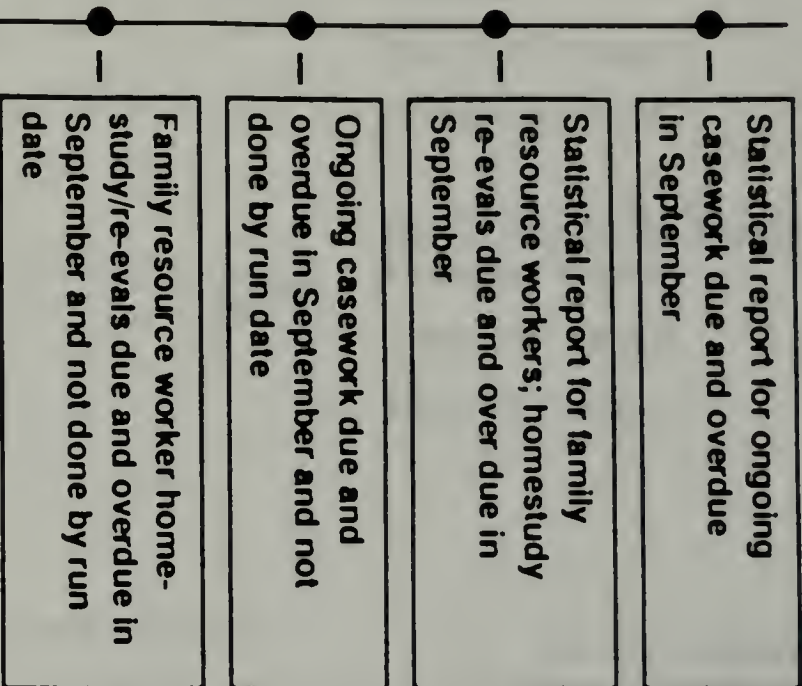
In addition, DSS will be implementing a new ASSIST case practice monitoring report. This report will enable social workers to more effectively plan over a 2 month period. This report will show all activity (assessment, case reviews, and service plans) over a 2 month period. (See attached). Case practice compliance statistics will be more accurate then in the past.

Intensive assessment training (the basis for case reviews) has been planned for the fall. A new curriculum has been developed and will be implemented area by area.

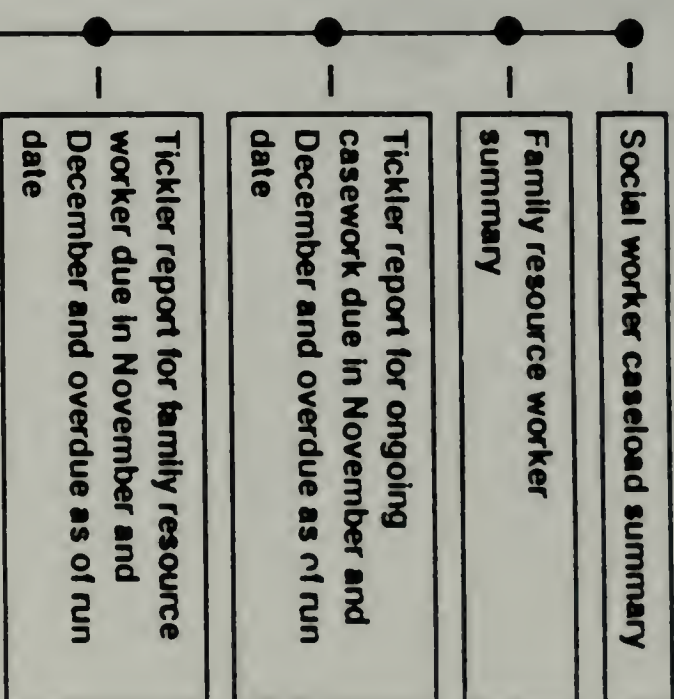
AREA OFFICE ASSIST REPORTS

NEW OR AMENDED REPORTS

Preliminary statistical and exception reports



Final statistical and exception reports



October 10th

20th *

Friday after 20th

Reports that will continue unchanged

- ★ Timelines of investigation of child abuse and neglect reports screened-in in the month of September
- ★ Reports and investigations not investigated in a timely manner
- ★ Family closings for the month of September
- ★ Social worker monthly workload activity report

* Because October 20 is a Saturday, the actual run date that month will be the 19th.

Reports Distributed to Area Office/PAS Agencies

0658	SW Caseload Summary	
0721	Permanency Planning Report	Social Worker Summary
0001	Area Based Monthly Tickler	Tickler Report for ongoing casework
0443	Assessment Tickler	
0788	Service Plans Overdue	
04776	Social Worker Health Care Tickler	Statistical Report
0002 *	Monthly Tickler	Exception Report
0705A *	Foster Care Homestudy Status	Tickler Report for Family Resource Worker
0758 *	Children In Foster Homes	
0708A *	Adoption Homestudy Status	
0759 *	Children in Adoptive Homes by Provider	Statistical Report
0751	Foster Care Program Restricted and Reeval	Exception Report
0500	List of Authos Needing Update	
0510	Consumers Receiving Extraordinary Expenses.Spec. Services	• Family Resource Worker Summary

0464	Family Closing
0832 B	Timeliness of Investigations
0832 C	Not Investigated in a Timely Fashion
0488 B	Social Worker Monthly Workload Activity

0003	Turnaround Document Report (form)
0433	Face Sheet (form)
4516	Autho for Service Update (form)
4517	Autho for Service Update (form)

Continued per Curent Format

SOCIAL WORKER NO: 001070111

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF SOCIAL SERVICES
A.S.S.I.S.T.
SOCIAL WORKER CASELOAD SUMMARY

SOCIAL WORKER NAME: WORCESTER

DATE 04/03/90

FAMILY NO CONSUMER NO	LAST NAME	FIRST NAME	DOB	RELATIONSHIP ETHNICITY/LANG	PLACEMENT TYPE CASE INFORMATION	DATE
100002000	TANVER	MICHAEL	10/11/1983	CHILD WHITE /ENGLISH	INITIAL CONTACT NOT IN PLACEMENT	10/08/88 OTHER 10/08/88
102301	TANVER	ELLEN	02/07/1980	CHILD WHITE /ENGLISH	INITIAL CONTACT NOT IN PLACEMENT LEGAL STATUS ASSESSMENT	10/08/88 OTHER 10/01/88 11/05/88 DSS CUS PERI(NON-CHINS) 11/08/88 INITIAL ASSESSMENT
100002003	BEEMAN	CHRISTOPHER	04/16/1986	CHILD BLACK /ENGLISH	INITIAL CONTACT FOSTER HOME (UNRELATED) LEGAL STATUS ASSESSMENT	11/14/88 OTHER 05/07/89 * 09/30/89 DSS CUS TEMP(NON-CHINS) 12/01/88 INITIAL ASSESSMENT
102442	BEEMAN	JANE	02/03/1966	CHILD WHITE /ENGLISH	INITIAL CONTACT COMMUNITY RESIDENCE	11/14/88 REQUEST FOR SERVICES 01/01/89 *
100002010	BRENNAN	HOLLY	08/10/1983	CHILD WHITE /ENGLISH	INITIAL CONTACT NOT IN PLACEMENT	09/25/88 REQUEST FOR SERVICES 09/25/88
102323	BRENNAN	ANREM	05/25/1985	CHILD WHITE /ENGLISH	INITIAL CONTACT NOT IN PLACEMENT	09/25/88 REQUEST FOR SERVICES 09/25/88
102324	BRENNAN	ALLISON	06/14/1980	CHILD WHITE /ENGLISH	INITIAL CONTACT NOT IN PLACEMENT	09/25/88 REQUEST FOR SERVICES 09/25/88

NUMBER OF CONSUMERS: 7
NUMBER OF FAMILIES: 3
NUMBER OF CONSUMERS
IN PLACEMENT: 2

* = DATE INTO CONTINUOUS PLACEMENT

0060106 CASEWORK TICKLER

CASEWORKER: 001010111 SALLY SMITH

FAMILY NO CONSUMER NO	CONSUMER NAME	ROLE IN FAMILY	ASSESSMENT DUE DATE	SRV PLAN DUE DATE	AREA BASED REVIEW DUE DATE	FCR DUE DATE	RIN MED EXAM DUE DATE	RIN DENT EXAM DUE DATE
100000001	ALICE ADDAMS	PARENT	03/08/89	03/23/89				
200000001	CHARLES ADDAMS	CHILD	03/08/89	03/23/89			02/07/89	02/29/89
200000002	DELIA BROCK	UNRELATED CHILD	03/08/89	AR 03/23/89			03/01/89	
100000002	EDWARD CHAPEL	CHILD		10/22/88	02/10/89		01/12/89	12/09/88
200000004	FREDDA CHAPEL	GRANDPARENT		10/22/88				
200000005	GLENDA CHAPEL	PARENT		10/22/88	02/10/89			
100000003	HAROLD DUNN	PARENT	11/21/88	12/06/88		03/15/89		
200000007	INEZ DUNN	CHILD	11/21/88	12/06/88		03/15/89		
200000008	JOYCE ENDERBY	CHILD	11/21/88	12/06/88		03/15/89		
200000009								

* - OVERDUE
AR - ADMINISTRATIVE REVIEW DUE

DEPARTMENT OF SOCIAL SERVICES
OFFICE FOR SYSTEMS
PROPOSED ONGOING CASEWORK TICKLER

05/22/90

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CRP0027A

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF SOCIAL SERVICES
A.S.S.I.S.T.
ONGOING CASEWORK
DUE & OVERDUE IN THE MONTH OF FEBRUARY
AND NOT DONE BY 03/10/89

DATE 03/10/89

AREA 010 PITTSFIELD

• • • D U E D A T E S • • •

FAMILY NUMBER CONSUMER NUMBER	CONSUMER NAME	ASSESSMT DUE DATE	SVC PLAN DUE DATE	AREA BASED REVIEW DUE DATE	RTN MED DUE DATE	RTN DENT DUE DATE	CASE WORKER NUMBER	CASE WORKER NAME
1000000002	EDWARD CHAPEL	08/10/88	10/22/88	02/10/89			001010111	SALLY SMITH
2000000004	FREDDA CHAPEL	10/15/88	10/22/88				101010111	SALLY SMITH
2000000005	GLENDIA CHAPEL	08/10/88	10/22/88	02/10/89			001010111	SALLY SMITH
1000000003	HAROLD DUNN	09/15/88					001010111	SALLY SMITH
2000000007	INEZ DUNN	09/15/88					001010111	SALLY SMITH
2000000008	JOYCE ENDERBY	11/30/88					001010111	SALLY SMITH

ON GOING EXCEPTION REPORT

ONGOING STATISTICAL REPORT

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DEPARTMENT OF SOCIAL SERVICES
OFFICE FOR SYSTEMS
PROPOSED ONGOING CASEWORK TICKLER

05/22/90

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CRP0026A

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF SOCIAL SERVICES
A.S.S.I.S.T.
STATISTICAL REPORT FOR
ONGOING CASEWORK
DUE AND OVERDUE IN THE MONTH OF JANUARY

DATE: 02/10/89

CASEWORKER: 001010111 SALLY SMITH

• INITIAL ASSESSMENTS		4	DONE IN 45 DAYS	6	60 %	10	100 %
DUE	:	6	DONE IN 46 TO 60 DAYS	3	30 %	0	0 %
OVERDUE	:	10	DONE IN MORE THAN 60 DAYS	1	10 %	0	0 %
TOTAL	:		TOTAL DONE				
	:		NOT DONE BY RUN DATE				
	:		CLOSED				
• INITIAL SERVICE PLANS		5	DONE IN 55 DAYS	7	58 %	10	83 %
DUE	:	7	DONE IN 56 TO 70 DAYS	2	16 %	2	16 %
OVERDUE	:	12	DONE IN MORE THAN 70 DAYS	1	8 %	0	0 %
TOTAL	:		TOTAL DONE				
	:		NOT DONE BY RUN DATE				
	:		CLOSED				
• SERVICE PLANS		11	DONE BY DUE DATE	11	100 %	11	100 %
DUE	:	0	DONE AFTER DUE DATE	0	0 %	0	0 %
OVERDUE	:	11	TOTAL DONE			0	0 %
TOTAL	:		NOT DONE BY RUN DATE			0	0 %
	:		CLOSED				
	:		OTHER				
AREA BASED REVIEWS		12	DONE BY DUE DATE	8	57 %	9	64 %
DUE	:	2	DONE AFTER DUE DATE	1	7 %	5	36 %
OVERDUE	:	14	TOTAL DONE			0	0 %
TOTAL	:		NOT DONE BY RUN DATE			0	0 %
	:		CLOSED				
	:		OTHER				
• ROUTINE MEDICAL EXAMS FOR CONSUMERS IN PLACEMENT MORE THAN 3 MONTHS		6	DONE BY DUE DATE	5	71 %	6	86 %
DUE	:	1	DONE AFTER DUE DATE	1	14 %	1	14 %
OVERDUE	:	7	TOTAL DONE			0	0 %
TOTAL	:		NOT DONE BY RUN DATE				
	:		CLOSED				
	:		OTHER				
• ROUTINE DENTAL EXAMS FOR CONSUMERS IN PLACEMENT MORE THAN 3 MONTHS		7	DONE BY DUE DATE	8	89 %	9	100 %
DUE	:	2	DONE AFTER DUE DATE	1	11 %	0	0 %
OVERDUE	:	9	TOTAL DONE			0	0 %
TOTAL	:		NOT DONE BY RUN DATE				
	:		CLOSED				

NOTE: DUE TO ROUNDING: PERCENTAGES MAY NOT ADD UP TO 100 %.

FAMILY RESOURCES WORKER SUMMARY

PA 01 DEPARTMENT OF SOCIAL SERVICES 12/01/89

OFFICE FOR SYSTEMS
PRODUCED FAMILY RESOURCE WORKER TICKET

PROVIDER: F. MACGILL
DEPARTMENT OF SOCIAL SERVICES
FAMILY RESOURCE WORKER
SUMMARY
AS OF 12/01/89

FAMILY RESOURCE WORKER: 001010115 SCOTT, MARY

PROVIDER NUMBER	PROVIDER NAME ADDRESS, TELEPHONE	PROVIDER STATUS AND DATE	PROGRAM STATUS AND DATE	HOME STUDY / RE-EVAL DATE	MAP DATE	FOS PGM CD
1009547ADP	HELEN FRENCH 326 WASHINGTON ST PITTSFIELD MA 01201 0000 (413)499-3434	PREQUALIFIED HOMEHOLD 02/24/89	STR:CS 05/07/89	06/07/89		1
250999	-FAMILY# -CONSUMER NAME 123456789 JENNIFER LEWIS	-DOB -DOP 03/20/86 11/24/89	FDSI	0 0	001010789 GREY, DORIS	
8076543	PATSY WATERS 132 BARTH STREET NORTH ADAMS MA 01247 0000 (413)664-9261	PREQUALIFIED HOUSEHOLD 11/22/89	STR:CS 11/22/89	11/22/89		2
462999	-FAMILY# -CONSUMER NAME 123000000 ALYSSA ROBERTS 463000 123000000 KENNY ROBERTS	-DOB -DOP 02/14/85 10/14/86	FDSI	0 0	001010789 GREY, DORIS 001010789 GREY, DORIS	
8909079ADP	WILLIAM FAUST 12 KENNEDY DRIVE NORTH ADAMS MA 01247 0000 (413)664-9123	PREQUALIFIED HOUSEHOLD 09/22/89	UNRSTR 09/22/89	09/22/89		2
502345	-FAMILY# -CONSUMER NAME 040090789 ELLEN STORM	-DOB -DOP 07/04/80 01/14/87	FDSI	0 0	001010062 YEHOM, JEAN	

ADP - PROVIDER APPEARS ON THE ONLINE ADOPTION MATCH FUNCTION

FAMILY Resource Worker Tracker

DEPARTMENT OF SOCIAL SERVICES
 OFFICE FOR CITIZEN
 PROPOSED FAMILY RESOURCE WORKER
 01/17/89

PAGE 01
 CR00011A
 COMMONWEALTH OF MASSACHUSETTS
 DEPARTMENT OF SOCIAL SERVICES
 A.S.S.I.S.I.
 TICKET REPORT FOR
 FAMILY RESOURCE WORKER
 DUE IN FEBRUARY AND MARCH
 AND OVERDUE AS OF JANUARY 27, 1989
 DATE 01/27/89

FAMILY RESOURCE WORKER - 001010111		SMITH, SALLY									
PROVIDER #	PROVIDER NAME	CASEWORKER # AND NAME	DATE OF PLAC	FCR DUE DATE	RIM MED EXAM DUE DATE	RIM DENT EXAM DUE DATE	FOS REF AUTO DUE DATE	PACT REF AUTO DUE DATE	HOME STUDY /RE EVAL DUE DATE	LAST COPY DATE	FOS PGM STATUS
0001234	JANE FOSTER								01/15/89	12/01/88	UMRSTR
100000001											
200000001	LEE, MARY	001010234	WEEKS, KATHY	11/23/88	02/15/89	02/15/89	02/28/89	02/11/89			
200000002	LEE, FRED	001010234	WEEKS, KATHY	11/23/88	02/15/89	03/01/89					
200000003	JONES, JULIE	001010234	WEEKS, KATHY								
100000002											
200000004	ROGERS, KEVIN	001010235	SULLIVAN, GEORGE	03/22/88	03/01/89	01/12/89	12/09/88				
100000008											
200000005	DRUCKER, LUCY	001010235	SULLIVAN, GEORGE	10/22/88	02/01/89						
200000006	DRUCKER, THOMAS	001925123	LEWIS, TERRY	10/22/88	02/01/89						
0003456	LARRY PETERS										
100000012											
200000011	WILLIAMS, YV	001010768	KELLY, LOIS	11/02/87	01/27/89						
200000012	WILLIAMS, LAURA	001020987	THOMPSON, MARY	03/20/87			02/14/89	02/14/89			
100000025											
200000014	ROBERTS, KYIE	001010235	SULLIVAN, GEORGE	01/24/88	01/02/89	12/12/88	12/28/88				

- - OVERDUE

FAMILY

RESOURCES

EXCEPTION

REPORT

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DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE SYSTEMS
PROPOSED FAMILY REEVALUATION

PAGE 01
CRP0029A

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF SOCIAL SERVICES
A.S.S.I.S.T.
FAMILY RESOURCE WORKER
HOME STUDY/RE-EVALS
DUE & OVERDUE IN THE MONTH OF FEBRUARY
AND NOT DONE BY 03/10/89

DATE: 03/10/89

FAMILY RESOURCE WORKER: 001010112 JONES, LUCY			
PROVIDER NUMBER	PROVIDER NAME	CHILD SPECIFIC HOME STUDY DUE DATE	UNRESTRICTED HOME STUDY DUE DATE
1008765	HARRY FROST	02/14/89	
9006786	FRED GREEN		01/15/89
8067453	JENNIFER THOMAS		01/31/89

Family Resource Statistical Report

PAGE :
 DEPARTMENT OF SOCIAL SERVICES
 OFFICE FOR SYSTEMS
 PRODUCED FAMILY RESOURCE WORKER TIGLIP

1/2/91

PAGE 01
 CRPO0284

COMMONWEALTH OF MASSACHUSETTS
 DEPARTMENT OF SOCIAL SERVICES
 A.S.S.I.S.T

DATE - 03/10/89

STATISTICAL REPORT FOR
 FAMILY RESOURCE WORKER
 HOME STUDY/RE-EVALS
 DUE AND OVERDUE IN THE MONTH OF FEBRUARY

FAMILY RESOURCE WORKER: 001010111 SMITH, SALLY

• HOME STUDIES - CHILD SPECIFIC			
DUE	0	DONE IN 20 WORKING DAYS	: 0
OVERDUE	: 0	DONE IN MORE THAN 20 WORKING DAYS	: 0
TOTAL	0	TOTAL DONE	: 0
		NOT DONE BY RUN DATE	: 0
			0%
• HOME STUDIES - UNRESTRICTED			
DUE	: 0	DONE IN 4 MOS	: 0
OVERDUE	: 0	DONE IN MORE THAN 4 MOS	: 0
TOTAL	0	TOTAL DONE	: 0
		NOT DONE BY RUN DATE	: 0
			0%
• RE-EVALS			
DUE	: 0	DONE IN 1 YEAR	: 0
OVERDUE	: 1	DONE IN MORE THAN 1 YEAR	: 1
TOTAL	1	TOTAL DONE	: 1
		NOT DONE BY RUN DATE	: 0
			100%
			0%

PROVIDER REGISTRATION ADD/UPDATE

1. Application Type ☐ Add/Update Add ☐ Reapplication ☐ Applicant Update		2. Provider Number 		3. Worker Number 	
4. SSN or FEI # 			5. Suffix 		
6. Provider Name [Maximum 40 Characters]					
7. Does Business As (DBA) [Maximum 40 Characters]					
8. Search Name [Maximum 40 Characters]					
9. Contact Person [Maximum 40 Characters]					
MAILING ADDRESS					
10. Street Address/RFD/P.O. Box #			11. GEO Code 		12. Zip Code
13. City (If Out-Of-State)		14. State or Province		15. Country	
16. Telephone Area Code					
17. Send Check In-Care-Of [Maximum 40 Characters]					
LOCATION ADDRESS (If different from Mailing Address)					
18. Street Address/RFD/P.O. Box #			19. GEO Code 		20. Zip Code
21. City (If Out-Of-State)		22. State or Province		23. Country	
24. Telephone Area Code					
25. Organization Type ☐ 001 Corporation-Profit ☐ 002 Corporation-Nonprofit ☐ 003 Municipality ☐ 004 Partnership ☐ 005 Limited Partnership ☐ 006 Individual ☐ 007 Sole Proprietorship			26. Organization Incorporated In Massachusetts? ☐ 001 Yes ☐ 002 No		27. Minority Business Enterprise (MBE) Status (Organizations Only) ☐ 001 Certified ☐ 003 Denied ☐ 002 Pending ☐ 004 Not Reque
28. Services To Be Delivered (Individuals Only) ☐ Adoption ☐ Adoption Subsidy ☒ Family Support Services (CHORE) ☐ Foster Care-Unrestricted ☐ Foster Care-Child Specific ☐ Guardianship Subsidy ☐ Independent Living ☐ Interstate Compact ☐ Medicaid Only ☐ Miscellaneous Services					
SIGNATURES					
29. Worker					30. Date
31. Supervisor					32. Date
33. Data Entry Operator					34. Date

INDIVIDUAL FAMILY RESOURCES: STATUS UPDATE AND CHARACTERISTICS

1. PROVIDER #	2. PROVIDER NAME	3. WORKER #	4. New FR Wkr Assigned? (Y/N)	5. Date Assigned
		0 0	()	mm ad yy
HOMESTUDY/RE-EVALUATION STATUS UPDATE		6. Approved Home? □ 001 Yes □ 002 No	7. Homestudy/ Re-evaluation Effective Date	8. MAPP Trained? □ 001 Yes □ 002 No
			mm ad yy	mm yy
RESOURCE CHARACTERISTICS	11. Service Code FOS	12. Program Code □ 1 FOS: With Relative □ 4 FOS: Invoiced-With Relative □ 2 FOS: Unrelated Foster Home □ 5 FOS: Invoiced-Unrelated Foster Home □ 3 FOS: Adoptive Home □ 6 FOS: Invoiced-Adoptive Home		13. Adoption Match? (Complete for FOS 2 and FOS 5 only) □ 001 Yes □ 002 No
10. □ Add □ Update				

Identifying Information

14. Date of Birth mm dd yy	15. Sex ☐ 001 Male ☐ 002 Female	16. Marital Status ☐ 001 Never Married ☐ 003 Separated ☐ 005 Widowed ☐ 002 Married ☐ 004 Divorced
---	---	--

Basic Characteristics

17. Ethnicity (Check one)

☐ 001 Black	☐ 008 Native American
☐ 002 White	☐ 009 Portuguese
☐ 003 Puerto Rican	☐ 010 Cape Verdean
☐ 004 Cuban	☐ 011 Vietnamese
☐ 005 Mexican	☐ 012 Cambodian
☐ 006 Other Hispanic	☐ 013 Laotian
☐ 007 Asian/Pacific Islander	☐ 999 Other _____

18. Languages Spoken in Household (Check all that apply)

☐ 001 English	☐ 008 Haitian Creole
☐ 002 Spanish	☐ 009 Chinese
☐ 003 Portuguese	☐ 010 Vietnamese
☐ 004 Cape Verdean Creole	☐ 011 Khmer (Cambodian)
☐ 005 Italian	☐ 012 Lao
☐ 006 Greek	☐ 013 Sign Language
☐ 007 French	☐ 999 Other _____

Specific Characteristics

Recommended Slots	19. Total Capacity (Children)	20. Retainer? ☐ 001 Yes ☐ 002 No	
21. Number of Children	22. Sex ☐ 001 Male ☐ 003 Both ☐ 002 Female	23. Minimum Age	24. Maximum Age
25. Number of Children	26. Sex ☐ 001 Male ☐ 003 Both ☐ 002 Female	27. Minimum Age	28. Maximum Age

29. Physical Characteristics	Specialty	Can't Handle	31. Behavioral Characteristics	Specialty	Can't Handle
001 Non-Ambulatory	☐	☐	001 Severe Behavior Disorder	☐	☐
002 Cerebral Palsy	☐	☐	002 Acting Out/Aggressive	☐	☐
003 Seizure Disorder	☐	☐	003 Sexually Active	☐	☐
004 Vision Impairment	☐	☐	004 Running Away	☐	☐
005 Hearing Impairment	☐	☐	005 Tantrums	☐	☐
006 Motion Impairment	☐	☐	006 Alcohol Abuse	☐	☐
007 Chronic Medical Condition	☐	☐	007 Drug Abuse	☐	☐
008 Physical Disability	☐	☐	008 Fire Starting	☐	☐
009 Encopresis/Eneuresis	☐	☐	009 School Adjustment Problems	☐	☐
010 Apnea	☐	☐	010 Eating Disorders	☐	☐
011 Communicable Diseases	☐	☐	011 Poor Social Skills	☐	☐
			012 Stealing	☐	☐

30. Emotional Characteristics	Specialty	Can't Handle	32. Cognitive Characteristics	Specialty	Can't Handle
001 General Emotional Disorder	☐	☐	001 Mental Retardation	☐	☐
002 History of Abuse/Neglect	☐	☐	002 Learning Disorder	☐	☐
003 History of Sexual Abuse	☐	☐	003 Speech/Language Impairment	☐	☐
004 Hyperactivity	☐	☐	004 Autism	☐	☐
005 Depression	☐	☐			
006 Suicidal	☐	☐			
007 Psychosis	☐	☐			

33. Other Characteristics	Specialty	Can't Handle
001 Pregnant Teen	☐	☐
002 Parenting Teen	☐	☐
003 Smoking	☐	☐
999 Other _____	☐	☐

GOAL 7: TO MAINTAIN STATEWIDE IMPLEMENTATION OF THE FOSTER CARE REVIEW UNIT

Status of FY'90 Goal/Objectives

A. Maintenance Objectives

1. The Foster Care Review Unit has continued to conduct over 90% of all case reviews in the month they were due with the exception of the months of November 1989, January and March 1990 in which they were 89%, 87% and 89% respectively. (Assist Report #NDSS34).
2. The participation of social workers and/or other field staff has been well over 90%. However, the participation of 2nd party has been only at around 85% level. (Assist Report NDSS062). Such below 90% performance appears to indicate the increased workload at the area level as well as the inclusion of PAS agencies which often times have no capability to provide an administrator for the 2nd party's function in the review because of the small size of the agencies. The participation levels of parents, foster parents, and mature children was in the neighborhood of 40%, just about the same as the past year. (Assist Report #NDSS0062).
3. In FY'90, the volunteer pool declined from 448 volunteers on June 30, 1989 to 414 on June 30, 1990. Some of the reasons for the decline related to the loss of two Volunteer Coordinators for the Unit and at the same time, the new focus of the Unit on training Volunteer Primary Reviewers because of the increasing load for Reviewers. The Volunteer Primary Reviewers are virtually all recruited from the pool of third party reviewers and consequently, the recruitment effort of primary reviewers could not have resulted in higher number of the total pool.

The third party participation rate for FY'90 averaged 56%. The Unit doesn't envision the rate for third party participation to improve significantly because of the cutbacks and our priority for reviews to be completed for the month they are due.

B. FY'90 Maintenance of Permanency Planning Policy

Goals

The Foster Care Review Unit conducted approximately 12,000 reviews during FY'90. As the Unit covers the whole state and has access to data in aggregate, the Unit can, with the proper tools and data gathering instruments, analyze data in broader terms. The Unit theoretically can capture emerging trends statewide in the area of permanency planning with strong policy development implications.

GOAL 7: TO MAINTAIN STATEWIDE IMPLEMENTATION OF THE FOSTER CARE REVIEW UNIT (cont'd)

For FY'91 the Unit has committed itself to the finalization of Form 5 and Form 6 revisions to be entered in the P.C.s so that data can easily be retrieved for analysis.

1. Earlier plan to redistribute monthly FCRU report has been delayed until FY'91 when Form 5 and Form 6 are finally revised.
2. The system is in place to "red flag" cases in which excessive delay in permanency planning is an issue and/or casework direction is not consistent with the permanency goals. Area Offices are notified of those "red flagged" cases, so that appropriate action could be taken to correct the delay.
3. Foster care review documents are now routinely used for court conducted dispositional hearings.

C. Revised FY'90 Objectives

In the face of budgetary cuts and dwindling resources taking place during the year, plans had to be made to increase productivity to cover the demand of the workload. The management had developed a two-pronged approach to deal with the increasing workload in the Unit. A decision was made to begin training of Volunteer Primary Reviewers for certain cases that are deemed appropriate for them. Criteria were developed to define "progress review" cases. Such cases will be less demanding of staff's time and thus can increase the number of cases reviewed at a given time. The total number of reviews assigned to staff in the Unit increased 25% since April 1990.

The first group of Volunteer Primary Case Reviewers completed the training in February 1990 and began doing reviews in March. This initial pilot project was reasonably successful. Of the twenty seven Volunteer Primary Reviewers, eighteen have remained to serve in that capacity. The following are the breakdowns of reviews assigned them between 3/90 - 8/90.

<u>Month</u>	<u># of Reviews Scheduled</u>
March	27
April	37
May	28
June	30
July	47
August	40

There are plans to start the training for the second group in FY'91.

GOAL 7: TO MAINTAIN STATEWIDE IMPLEMENTATION OF THE FOSTER CARE REVIEW UNIT (cont'd)

D. FY'90 Training and Staff Support Goals

1. Because of the changes the Unit has faced during the year and the anticipation of more changes to come, the FCRU engaged a consultant to provide a workshop on "change management". In addition, the staff has been provided training in the use of laptop computers. The above focus of the training reflected immediate needs and priorities of the Unit.
2. The Unit has revised and updated pre-orientation training curriculum for Citizen Volunteer Reviewers.
3. A volunteer appreciation event was successfully held on June 20, 1990 with the largest attendance for such events in the Unit.
4. One of the Data Entry Operators in the Unit was recognized as the Employee of the Month in the Central Office.
5. FY'90 marked the beginning use of laptop computers among staff in the FCRU to increase efficiency and productivity. Most of the reviewers have received hands-on training for laptops and found them to be effective tools for their tasks.

FY'91 Goals

A. FY'91 Maintenance of Performance Goals

The Foster Care Review system has been established by the mandate of Chapter 197 and the requirements to comply with current recertification under P.L. 96-272 which qualifies Federal reimbursements. Federal reimbursements are important for the Department's permanency planning programs and are crucial for the operation of the FCRU. However, the mission of this Unit goes far beyond satisfying the reimbursement requirements. The unit has as its mission of ensuring that permanency plans are appropriately implemented in cases of children in placements. Through the work of the Unit along with efforts of the Area Office staff, we hope to safeguard the welfare of every single child in the care of the Department.

Maintenance Performance Objectives

1. To complete 90% of all case reviews during the month in which they are due.
2. To assist Area Offices in maintaining the participation of social workers and second party reviewers at 90%.

GOAL 7: TO MAINTAIN STATEWIDE IMPLEMENTATION OF THE FOSTER CARE REVIEW UNIT (cont'd)

3. To continue to recruit/maintain, and support a pool of volunteers as primary case reviewers to cope with the ever increasing workload for reviewers.
4. To recruit, maintain and support a pool of voluntary third-party reviewers to closely reflect socio-demographic variables of the DSS substitute care case-load and sufficient to schedule volunteers for reviews for at least 60% of the cases due.
5. To encourage the Area Offices to increase the rate of participation of the biological parents, foster parents/substitute caretakers and mature children from the current 40% to at least 50% level.
6. To achieve higher efficiency of operations by automation through the use of laptop computers, letter folding machine and P.C.s. To support such use of sophisticated equipments by the provision of training to staff and the availability of such equipments.
7. To refine tools for data collection by completing the revision of Form 5 and Form 6 and entering such data into the Unit's P.C.s for easy data retrieval.
8. To produce an annual FCRU report for FY'91.
9. To continue streamlining Unit's operation such as revising and simplifying narratives to allow staff to function more efficiently.

B. FY'91 Maintenance of Permanency Planning Policy Goals

The Foster Care Reveiw Unit will conduct approximately 13,000 reviews in FY'91. With the wealth of data collected by this Unit, it is important that data be utilized in aggregate to identify emerging trends in the area of permanency planning as well as the general child welfare practices in the field. With the tools and equipments in place as discussed earlier, the Unit can finally begin to assume a larger role in providing insights and assessment for policy development at Central Office. This also calls for close collaboration with other Units, particularly the Deputy Commissioner's Office, to achieve the above goal.

1. Continue the current system of alerting Area Directors on cases that encounter delay in the implementation of permanency planning.
2. Continue to furnish foster care review documents for court conducted dispositional hearings.

GOAL 7: TO MAINTAIN STATEWIDE IMPLEMENTATION OF THE FOSTER CARE
REVIEW UNIT (cont'd)

3. To use newly revised Form 5 and Form 6 for identification of barriers to permanency planning in cases reviewed.

C. FY'91 Training Goals for FCRU Staff

1. To provide the follow-up workshop on "management of change" to FCRU staff.
2. To provide training on two important topics that have immediate relevance to the work of our reviewers.
 - a. Substance abuse families and their role in permanency planning. In view of the implementation of Project Protect and the prevalence of such addiction problems among the families DSS serves, we envision the topic will increasingly be part of the review focus.
 - b. Conflict management has become a skill paramount in our reviewers' ability to successfully do their work. In a case review session involving multiple parties with different goals and oftentimes conflicted interests, it is important for the reviewers to learn how to handle such conflicts so that the review can be successfully concluded.

GOAL 8: TO IMPROVE QUALITY HEALTH CARE SERVICES TO CHILDREN
IN SUBSTITUTE CARE, INCLUDING CHILDREN WITH AIDS

Area office compliance with the "Health Care Services to Children In Placement" policy continues to be closely monitored by the Deputy Commissioner's office. The health visit computer tracking system generates a monthly report which shows the percentage of children in substitute care who have up-to-date medical and dental examinations, and the percentage of the medical examinations that are in compliance with Project Good Health's Protocol (EPSDT). During FY90, this report was incorporated into a general report circulated to social work staff on a monthly basis as a reminder of children's due dates for medical and dental appointments as well as foster care reviews. The Medical Passport, which is issued to all children in substitute care, records health history and current health problems/needs. The Department's area based Registered Nurses provide training, consultation, and technical assistance to social work staff.

The Department employs a number of health care professionals in addition to the Registered Nurses. Two Public Health Nurse Advisors, located in the Family Life Center, assess the health care needs of children and families, and assist social workers in the development of health care plans. The Public Health Nurse Advisor is the Family Life Center's liaison to the AIDS Review Board. Two pediatricians located in the Family Life Center conduct assessments in protective cases, coordinate medical care, provide consultation to social work staff and act as

GOAL 8: TO IMPROVE QUALITY HEALTH CARE SERVICES TO CHILDREN
IN SUBSTITUTE CARE, INCLUDING CHILDREN WITH AIDS (cont'd)

a link between the Department and the medical community.

In December of 1988 the Department implemented a policy concerning children in the care and custody of the Department who are HIV involved. An AIDS Review Board comprised of experts in the field of AIDS and representatives of the Department's Central and Regional Offices was established to review all cases involving questions of HIV antibody testing, placement in substitute care, confidentiality, and enrollment in clinical trials. Though the Board's chair will readily account that the Board has developed its methods "inprocess", the proven efficacy of its methods have won the Board national and international acclaim. In 1989 the Child Welfare League of America recommended the Central AIDS Review Board as a model of decision making. The Board was also the subject of presentations at the 1989 International AIDS Conference in Montreal and the 1989 National Pediatric AIDS Conference in Los Angeles. The American Public Welfare Association (APWA) honored the AIDS Review Board in its 1990 innovations in State and Government Awards Program. The Board currently meets every two weeks and reviews an average of 25 cases per meeting.

The AIDS Board is currently planning to revise the Department policies addressing decision making for children in the care and custody of the Department with known or suspected HIV infection. One proposal being

GOAL 8: TO IMPROVE QUALITY HEALTH CARE SERVICES TO CHILDREN
IN SUBSTITUTE CARE, INCLUDING CHILDREN WITH AIDS (cont'd)

discussed involves developing "AIDS Review Teams" within each of the Department's Field Support Offices. "AIDS Review Teams" will be modeled in structure and function after the Central AIDS Board though their decision making authority would be limited to more routine placement and testing decisions. The Central AIDS Board would continue to review cases involving the most complex or controversial issues and would review all recommendations about research protocols to which children in DSS custody may be referred. In addition, the Board would retain responsibility for policy and procedure, training, and dissemination of new information about HIV to local teams and area staff, monitoring of the Field Support Teams and monitoring of HIV prevalence and outcomes in the DSS caseload.

The Board will be aided in its work by the ongoing services of a nurse who was hired in FY'90 through a Department of Public Health grant from NIHR to collect surveillance data. The nurse in cooperation with a data specialist from the Department of Public Health is developing a database which will cross reference information available through various health and human service systems to provide a profile on HIV involved children and their families unlike that available anywhere else in the U.S. The "surveillance nurse" also works to ensure that children reviewed by the AIDS Board receive adequate follow-up care.

GOAL 8: TO IMPROVE QUALITY HEALTH CARE SERVICES TO CHILDREN
IN SUBSTITUTE CARE, INCLUDING CHILDREN WITH AIDS (cont'd)

In 1988, the Department received a grant from the Department of Health and Human Services to establish the Child Care AIDS Network. The goals of the Child Care AIDS Network are to coordinate a statewide respite care exchange among foster families caring for high risk and HIV infected children and to recruit new foster families to care for HIV infected children.

During FY'90, this program proved enormously successful as over 50 foster families providing care to HIV involved children became active in the Network's respite exchange and a number of new foster families for HIV involved children were recruited through aggressive media efforts, outreach to community based organizations, and inclusion of foster parents in recruitment efforts. The Child Care AIDS Network, in conjunction with the Department's Training Unit, also sponsored statewide and area based training sessions for DSS staff and foster families on such topics as "Adolescence and AIDS" and "Intravenous Drug Use and AIDS".

The Child Care AIDS Network had been awarded an additional 17 months of DHHS funding extending CCAN's services into FY'92 (effective 10/90). FY'91 priorities for CCAN include continued foster parent recruitment, provision of the respite exchange, support services and training and development and distribution of a caregiver's manual and placement kit for families caring for HIV involved children.

GOAL 8: TO IMPROVE QUALITY HEALTH CARE SERVICES TO CHILDREN
IN SUBSTITUTE CARE, INCLUDING CHILDREN WITH AIDS (cont'd)

During FY'90, the Department collaborated with the Office for Children to develop the Family Residence Program: a new model of substitute care to better meet the needs of medically involved foster children and their families. Medically involved children include infants born with Fetal Alcohol Syndrome (FAS) or Narcotics Abstinence Syndrome (NAS), HIV involved children, and children with a medical illness/handicap that involves multiple systems or one system in a major way. The Family Residence's model is home-based, staffed by foster parents and health care support staff. Family Residences allow children who would normally require care in a more intensive setting to be cared for in a nurturing, home environment. To date four "Family Residences" with a total of 15 beds have been developed for medically involved children.

GOAL 9: TO COORDINATE THE DEPARTMENT'S INTERSTATE COMPACT ACTIVITIES

The Interstate Compact on the Placement of Children (ICPC) is a legal contract between signatory states that regulates and provides safeguards to the movement of children between states. Currently, all fifty states and the Virgin Islands are participants in the Interstate Compact Agreement.

The Compact provides a mechanism whereby an agency with an interest in a particular child is not hampered by state borders in determining the best placement of a child. It allows the "Sending Agency" confidence that the placement will be properly supervised even though it cannot provide the supervision directly. At the same time, it provides the "Receiving State" the opportunity to insure that the placement complies with all its laws, to determine the appropriateness of the placement, and to supervise the placement in the child's best interest towards permanency.

Role of the Department's ICPC Unit.

The ICPC Unit combines the function of the Compact Administrator and the public authority as identified in M.G.L. c.119, 36. Working under the supervision and direction of the Deputy Commissioner, who in Massachusetts has been designated by the Governor as the "Compact Administrator", the ICPC Unit is responsible for the following:

GOAL 9: TO COORDINATED THE DEPARTMENT'S INTERSTATE COMPACT
ACTIVITIES (cont'd)

- o Assuring that placements into and out of Massachusetts are made according to law;
- o Processing all referrals for interstate and inter-country placements;
- o Approving or disapproving placements to be made into the Commonwealth;
- o Approving or disapproving proposed termination of jurisdiction by sending agencies in other states over children placed in the Commonwealth;
- o Coordinating and facilitating the exchange of information between states regarding proposed and current interstate placements;
- o Identifying incidents of non-compliance and taking corrective action, including steps aimed at appropriate modification of non-compliance;
- o Maintaining a record on each child for whom planning of placement is being considered;
- o Giving necessary interpretation, clarification and direction regarding proposed placements;
- o Requesting additional information from DSS Area Offices or other related agencies, who give insufficient information in their referral or replies;
and

GOAL 9: TO COORDINATED THE DEPARTMENT'S INTERSTATE COMPACT
ACTIVITIES (cont'd)

- o Obtaining supervisory services and periodic reports from the receiving state, if placement is approved.

During an average month, the ICPC office receives 160 new referrals, approves 50 placements into Massachusetts and 55 placements out of Massachusetts, and closes 75 cases. The staff handles about 60 pieces of incoming mail and 80 telephone calls each day. At any given time, the ICPC office has 2500 open, active cases.

In an effort to handle the volume of paper work in the ICPC office, we have requested a consultation from our Office for Systems on the feasibility of automating many of the Office's activities.

Unfortunately, cutbacks in funding made it impossible for Massachusetts to participate in the annual meeting of ICPC administrators this past year.

GOAL 10: TO ASSURE APPROPRIATE SUPPORT PAYMENTS/FEDERAL BENEFITS ARE RECEIVED FOR CHILDREN IN SUBSTITUTE CARE

During FY'90, the Department updated comprehensive policies and case practice procedures relative to appropriate support resources for children in substitute care.

Support resources include, but are not limited to:

- o Title II/SSA Survivor's Benefits
- o Supplemental Security Income for Disabled Children
- o Title IV-D Child Support Payments
- o Other court-ordered Payments
- o Sliding fee participation by parents
- o Voluntary support payments
- o Title IV-E reimbursement

In FY'90, DSS issued its revised Sliding Fee Policy and Procedures. Area Administrative Managers were trained and the revised policy implemented in January, 1990. During FY'90, 349 families were assessed sliding fees; the average monthly fee is \$96.87; \$140,039 in sliding fee revenues was collected during the implementation phase. The Department is reviewing this implementation; Central office staff will work closely with Area Administrative Managers to improve the fee collection rate. A sliding fee revenue target of \$250,000 has been set for FY'91. The Department will also be reviewing the possibility of assessing sliding fees for children placed into care through court order. A decision will be made on this issue during FY'91.

GOAL 10: TO ASSURE APPROPRIATE SUPPORT PAYMENT/FEDERAL BENEFITS ARE RECEIVED FOR CHILDREN IN SUBSTITUTE CARE (cont'd)

During FY'90, the Department continued to meet with staff from the Department of Revenue - Office of Child Support Enforcement to implement the terms of the Interagency Agreement regarding Child Support Enforcement (Title IV-D). A small number of child support checks have been received on behalf of DSS children placed in substitute care. The two agencies must work further to develop an automated referral system so that DSS children in placement can be referred to DOR-OCSE in a timely manner. During September-October, 1990, DOR-OCSE will have a Systems Analyst meet with DSS Systems and Revenue staff to review data elements common to both agencies. For the period of November-December, 1990, testing of Interagency Data Reports will be conducted. A decision on the reporting/referral mechanism should be made in January, 1991, with complete data exchange following.

The Department significantly increased its Title IV-E claim during FY'90. An average of 3,600 children were claimed each quarter. A large part of the success of the Title IV-E Enhancement Project is due to the creation of a Revenue Field Team in October 1989. During FY'90, the members of the Revenue Field team visited each DSS Area Office, conducting reviews of over 8,000 children in substitute care (reviews were not conducted on those cases for which Title IV-E Eligibility has been determined). These comprehensive case reviews will continue during FY'91, with a goal, once again, of reviewing every child

GOAL 10: TO ASSURE APPROPRIATE SUPPORT PAYMENTS/FEDERAL BENEFITS
ARE RECEIVED FOR CHILDREN IN SUBSTITUTE CARE (cont'd)

newly placed into substitute care for federal benefit eligibility. As placement caseload numbers increase, it is expected that the IV-E claim numbers will continue to increase.

Members of the Revenue Unit and the DSS Systems Unit are designing an automated system which will account for the receipt and expenditure of client benefits. This system will include cross-referencing to the ASSIST, AUTHO and Title IV-E revenue systems, allowing for faster and more accurate tracking of child-specific benefits. A three-year plan will be designed by December, 1990.

GOAL 11: TO MAINTAIN THE ADMINISTRATION OF THE FAMILY REUNIFICATION BENEFITS PROGRAM AND THE SUBSIDIZED GUARDIANSHIP PROGRAM

The DSS Family Reunification Benefits Program provides financial assistance through the Department of Public Welfare for AFDC-eligible families whose children are in DSS short-term placement or who are returning home from placement. This program is jointly administered by DSS and DPW on an interagency basis. In FFY'91 the FRB staff plans:

- o To automate FRB utilizing the Authorization system.
- o To modify the computerized data-gathering program for the purpose of compiling, analyzing, and reporting data for FRB.
- o To revise policy and procedure to reflect changes.
- o To maintain interagency collaborations with DPW Central Office to insure effective processing and monitoring of FRB program.
- o To maintain a logging system for Extreme Hardship Waiver Cases.

The DSS Guardianship Program was designed to provide permanency planning for children in the Department's care who cannot return home or be adopted due to continuing ties with their biological families. This provides a more favorable and stable option than long term foster care for our older children. A Guardianship subsidy may be requested.

GOAL 11: TO MAINTAIN THE ADMINISTRATION OF THE FAMILY REUNIFICATION
BENEFITS PROGRAM AND THE SUBSIDIZED GUARDIANSHIP PROGRAM
(cont'd)

Goals for FY'91:

- o To revise statewide tracking system to monitor program utilization.
- o To continue to coordinate the implementation of policies and procedures with appropriate staff.
- o To effect policy and procedural changes as necessary, i.e., update application form and develop a reevaluation form, and develop PACT tracking form.
- o A targeted FY'91 goal of 300 guardianships has been established.

GOAL 12: TO CONTINUE TO PROVIDE ADOPTION SERVICES STATEWIDE

Area Based Adoption Services: In the fall of FY 90 all direct adoption services statewide were decentralized and provided at the area level. The area offices have been in the process of developing and refining full scale adoption service delivery models responsive to their particular client populations. In the spring of FY 90 a statewide Adoption Coordinator was added to the Central Office staff to monitor the development and implementation of adoption service delivery programs in the Areas. In FY 91 this Adoption Coordinator, while evaluating the effectiveness of the area based programs, will work toward identifying and implementing agency wide adoption training, as well as programmatic and ancillary resource needs.

Adoption and Guardianship Subsidy Program: In the spring of FY 90 the management of the Adoption Subsidy Program was centralized from the four existing Field Support Offices. The goals of centralization were: to utilize staff more efficiently, to promote consistency in the application of policy and procedures relevant to subsidy, and to promote and develop an automated payment system. Currently there are approximately 3,000 special needs children whose permanent families receive subsidy in Massachusetts.

Implementation of Adoption Tracking system: The automated adoption tracking events on ASSIST were operational by the end of FY 89. Currently the focus is on

GOAL 12: TO CONTINUE TO PROVIDE ADOPTION SERVICES STATEWIDE
(cont'd)

improving the timely entry of data and adding additional events to more effectively utilize the system for permanency planning monitoring.

Training: The Central Office Adoption Coordinator in FY 91 is collaborating with the Training Unit to develop and implement a Certificate Program in Permanency Planning. A basic and advanced curriculum in Adoption will be offered, targeting Supervisors and staff involved in the direct delivery of adoption service.

PRIORITY III

PREVENTION OF SUBSTITUTE CARE PLACEMENT

GOAL 13: TO PROVIDE SERVICES WHICH SUPPORT INTACT FAMILIES

In FY'89 the Department of Social Services managed approximately \$350 million in its Purchase of Service System (inclusive of voucher day care), through which the agency contracts with over 600 community-based service providers to deliver services to Massachusetts families and children. These services include:

- o Therapeutic Services (Counseling)
- o Day Care
- o Parent Aide
- o Crisis Intervention
- o Residential Care

During FY'90, major social service reductions (i.e., 35% to open referral providers), as well as a cut of over 2,300 day care slots, were required in the D.S.S. system due to reduced levels of revenue. These reductions will continue into FY'91.

In FY'90, the Department continued to refine its computerized system which monitors payments, tracks performance and ensures accountability of services. However, time was diverted from this effort and likely again will be during FY'91 in order to implement policies, procedures, and cuts made necessary by eroding revenues.

In FY'91, the Department's Purchase of Service system will have a budget approximately equal to that of FY'90. Reductions in certain services being offset by continuing growth in out-of-home placements. To the extent possible

GOAL 13: TO PROVIDE SERVICES WHICH SUPPORT INTACT FAMILIES
(cont'd)

the Department will continue to refine its computerized monitoring system for the purpose of tracking and ensuring accountability of these services.

D.S.S. DAY CARE PROVISION

D.S.S. subsidizes day care for three important purposes: to support families which have children with special needs or children at risk of neglect or abuse; to provide the specialized support often needed by teen parents and their children; and to enable low-income families to achieve and maintain economic self-sufficiency. From FY'84 to FY'89, the Department expanded the supply of subsidized day care by 12,000 slots, or 65%. During FY'90, this expansion ended abruptly.

In FY'90, D.S.S. administered over \$90 million in contracted day care. This includes 4,000 supportive services day care slots, and 407 slots for teen parents. Through an agreement with the Department of Public Welfare, D.S.S. also manages the Voucher Day Care program, an integral Choices (ET Choices) program, which allows ET participants and graduates to choose the most appropriate day care program for their needs. By the end of FY'89, D.S.S. was administering over 10,000 voucher day care slots of which D.S.S. directly funds 1,500.

The total number of state-subsidized day care slots for low-income families with a work-related need for child

GOAL 13: TO PROVIDE SERVICES WHICH SUPPORT INTACT FAMILIES
(cont'd)

care rose by 68% from FY'83 to FY'89. During FY'90, these slots decreased by 2,300. During the FY'83 - FY'90 period, the stock of supportive day care slots essentially remained stable.

GOAL 14: TO CONTINUE TO PROVIDE AND IDENTIFY SERVICES TO THE HOMELESS

DSS continues to be actively involved in the Commonwealth's effort to alleviate homelessness. In FY'88, DSS deployed 24 staff to help homeless families gain access to housing search services, employment and training programs, day care, counseling and child health and nutrition programs. Subsequently, all Area Offices identified staff to receive referrals of homeless families.

The Department has found that some homeless families require more than short-term emergency shelter to become ready to live independently in permanent housing. Since FY'87, the Department has established 16 transitional residential programs for homeless families, battered women and their children, older adolescents and parenting teens. These programs provide a supportive transition to independence for seriously troubled families currently living in hotels and motels. Our Goals in FY'91 include the following:

- o To continue to provide Central Office technical assistance to Area staff on housing, despite staff cutbacks.
- o To continue to participate on state and community coalitions to develop more low-income housing.

GOAL 14: TO CONTINUE TO PROVIDE AND IDENTIFY SERVICES TO THE HOMELESS (cont'd)

- o To continue to provide generic social services to over 3,000 homeless families.
- o To work with the Department of Public Welfare, the Executive Office of Human Services, and the Executive Office of Communities and Development to create a new assessment and intervention program for families at risk of homelessness.

PRIORITY IV

SERVICES TO ADOLESCENTS

GOAL 15: TO IMPROVE THE RANGE AND QUALITY OF SERVICES FOR ADOLESCENTS

The Department's PAYA Program (Preparing Adolescents for Young Adulthood) is a comprehensive initiative that focuses on enhancing the agency's capacity to respond to the needs of youth. The goals of this program are to provide social workers and foster parents with the resources needed to assist adolescents to more effectively prepare for the transition from foster care to self sufficient young adulthood.

The fundamental components of the initiative include a training curriculum, skill modules, document portfolio/ lifebook and Teen Yellow Pages of community resources.

The PAYA training guide addresses the special developmental needs of youth in out-of-home care and presents approaches and resources for helping youth learn specific -kills in life management.

The Independent Living Skills Modules incorporate a number of key topic areas, such as money, home and food management; job seeking skills; health and personal care skills; housing and transportation skills, etc. These skills modules are designed to provide the opportunity for the active participation of adolescents and foster parents/social workers in the process of assessing, learning and practicing independent living skills.

GOAL 15: TO IMPROVE THE RANGE AND QUALITY OF SERVICES FOR ADOLESCENTS (cont'd)

The document portfolio/lifebook is assembled by the adolescent with the assistance of his/her social worker and foster parent and will be used to support the process of mastering skills essential to the successful transition to independent living. The portfolio holds the youth's medical, educational, legal and personal information (e.g. medical passport, diploma, G.E.D. certificate, birth certificate, social security card, personal photos, etc.).

Upon completion of each PAYA Module, adolescents may request two incentive awards such as:

- o Quarterly clothing checks issued in the adolescent's own name;
- o Payment of Driver's education classes;
- o \$100 for deposit in a savings account;
- o \$100 for deposit in a checking account;
- o Payment of travel expenses (limit \$200) for adolescent to visit a school/college, job site or training program;
- o \$200 Savings bond;
- o Debit card at a department store (\$500 limit) - Available only to adolescents who have a part-time job.

In FY'90 over 15 "PAYA Training Conferences" were held in which over 50% of the Department's staff and foster parents working with adolescents were trained in how to use the PAYA modules. The PAYA training guide was also

GOAL 15: TO IMPROVE THE RANGE AND QUALITY OF SERVICES FOR ADOLESCENTS (cont'd)

translated into Spanish to increase its accessibility. Presentation of the Spanish PAYA and provision of ongoing technical assistance will be provided to foster families and area offices throughout FY'91. PAYA program staff are also developing a new PAYA module to meet the needs of pregnant and parenting teens.

PRIORITY V

ADMINISTRATIVE SUPPORT AND MAINTAINING PROFESSIONAL STANDARDS

GOAL 16: TO MAINTAIN A PRODUCTIVE WORK ENVIRONMENT

The Department continues to achieve compliance with both its Caseload/Workload standards and its Affirmative Action goals.

The hiring of direct service staff has been fully centralized through the equitable deployment of Central Office pool positions to Area Offices statewide. In order to maintain the established standards of 18:1 for generic workers and 12:1 for investigators, a detailed analysis of both staff turnover and caseload trends is performed each month to ensure the equitable distribution of available Central Office pool positions. The Monthly Management Report compiled by the Department provides information by Area Office and individual worker, and is the basis for this deployment of pool positions as a means to ensure that workers are not responsible for an excessive workload (defined as having over 22 cases for 2 consecutive months).

The ongoing recruitment of direct service workers continues as a priority activity, and in FY '90 has resulted in the filling of all available positions at DSS such that vacancies were virtually eliminated.

While administrative staff have continued to be reduced at DSS in FY '90, hiring has occurred only into direct service positions sufficient to address staff turnover and the realization of projected increases in caseload size.

The attached Table A reflects the composition of the Department's workforce relative to employment of protected classes of employees according to Federal and State Affirmative Action regulations. The data have been extracted from the most recent Quarterly Report submitted by DSS to the State Office of Affirmative Action in July 1990. Aggressive recruitment of these protected groups will continue in FY '91 so that we maintain the level of performance reflected here. In addition, the employment of bilingual workers will continue as a priority component of our recruitment activity so that the Department can effectively meet the needs of all of our clients.

The attached Table B reflects estimated staff levels in FY '91 to implement adjustments as necessary to address high caseloads as they occur. Through such adjustments, the Department can continue to meet the priority objective of maintaining a productive and supportive work environment over the next three years.

GOAL 16: TO MAINTAIN A PRODUCTIVE WORK ENVIRONMENT (cont'd)

TABLE A

WORKFORCE ANALYSIS - JUNE 1990

	<u>Total # of Employees</u>	<u>Total # of Minorities</u>	<u>% Rep.</u>	<u># of Women</u>	<u>% Rep.</u>
Official/ Administrator	236	45	19.1%	133	56.4%
Professional	2,242	481	21.5%	1,624	72.4%
Para- Professional	81	29	35.8%	72	88.9%
Technical	46	8	17.3%	28	60.9%
Office Clerical	343	89	25.9%	339	98.8%
Service Maintenance	6	3	50.0%	6	100 %
Skilled Craft	2	2	100 %	1	100 %
TOTAL	2,956	657	22.2%	2,203	74.5%
Certified Handicapped	44	4	9.1%	28	63.6%
Vietnam Era Veterans	33	1	3.0%	1	3.0%

GOAL 16: TO MAINTAIN A PRODUCTIVE WORK ENVIRONMENT (cont'd)

TABLE B

ESTIMATED STAFF LEVELS - FISCAL YEAR 1991

	<u>Total # of Employees</u>	<u>Total # of Minorities</u>	<u>% Rep.</u>	<u># of Women</u>	<u>% Rep.</u>
Official/ Administrator	213	40	19.1%	120	56.4%
Professional	2,330	500	21.5%	1,686	72.4%
Para- Professional	81	21	35.8%	72	88.9%
Technical	46	8	17.3%	28	60.9%
Office Clerical	343	89	25.9%	339	98.8%
Service Maintenance	6	3	50.0%	6	100 %
Skilled Craft	2	2	100 %	1	100 %
TOTAL	3,021	663	22.0%	2,252	74.5%

GOAL 17: TO MAINTAIN A PROFESSIONAL ADVISORY COMMITTEE FOR THE PURPOSE OF GIVING PROFESSIONAL ADVICE TO THE COMMISSIONER ON CASE PRACTICE, RESOURCES AND CHILD PROTECTIVE ISSUES

During FY'90, the Department's Professional Advisory Committee (PAC) has accomplished the following:

1. Under the leadership of the Assistant Commissioner for Professional Services, met quarterly to review randomly selected Department case records and all Case Investigation Unit (CIU) reports. Based upon these reviews, the PAC made recommendations to the Commissioner regarding important case practice and policy issues.
2. Held regular meetings of three subcommittees which were formed to take an in-depth look at important issues recurring in case records/reports reviewed. The subcommittees are: Family Violence/Substance Abuse, Access to the Courts, and Mental Health Issues. Subcommittees met quarterly, or on an as needed basis.

Family Violence/Substance Abuse Subcommittee members have been actively involved with Department staff in the development of guidelines and policies for the Department regarding the protection of children in families in which substance abuse and/or family violence place the children at risk.

Mental Health Subcommittee members reviewed Department policies, procedures and training curricula and submitted recommendations to the Commissioner regarding training for Department staff in relation to assessing mental health needs and identifying needed resources.

Access to the Courts Subcommittee members continued to meet to discuss solutions which might expedite the hearing of care and protection cases. A long-term solution discussed is the establishment of a family court system. While this approach would take three to four years, members suggested efforts should begin to promote this concept.

3. Expanded the role of PAC members as consultants to the Case Investigation Unit (CIU) staff. The new practice is that one PAC member is assigned to each CIU investigation, at the start of the investigation, for the purpose of providing feedback and consultation to the CIU investigator regarding the adequacy of Department, or Partnership Agency, casework provided to the family.
4. Served as the Advisory Committee for the Children's Justice Act Grant awarded by the National Center on Child Abuse and Neglect. This grant supports the development of Sexual Abuse Intervention Network (SAIN) Teams in Middlesex, Essex, Bristol and Suffolk counties. The purpose of these teams is to improve the handling of child abuse cases, particularly cases of child sexual abuse.

GOAL 17: TO MAINTAIN A PROFESSIONAL ADVISORY COMMITTEE FOR THE PURPOSE OF GIVING PROFESSIONAL ADVICE TO THE COMMISSIONER ON CASE PRACTICE, RESOURCES AND CHILD PROTECTIVE ISSUES
(cont'd)

5. Maintained a multidisciplinary membership comprised of attorneys, pediatricians, psychiatrists, child welfare specialists, and a representative of both the law enforcement system and the Massachusetts Association for Professional Foster Care.

FY'91 GOALS:

1. Continue to hold quarterly meetings and to review all CIU reports as well as randomly selected full case records. Based on these reviews, recommendations regarding case practice and policy issues will be made to the Commissioner. Reviews will focus on current trends in DSS caseload.
2. Hold the following subcommittee meetings at least quarterly and make formal recommendations to the Commissioner regarding practice and policy issues in each of the subcommittee topic areas.
 - The Family Violence/Substance Abuse Subcommittee will continue to play an active role in the development and implementation of the Department's initiative, Project Protect.
 - The Access to the Courts Subcommittee will continue to pursue efforts to ensure that courts expedite care and protection cases.
 - The Mental Health Subcommittee will review the Department's Mental Health Needs Assessment report and make recommendations as needed.
 - A new subcommittee will begin to meet to discuss issues related to substance abuse and the 51A Reporting Law.
3. Continue to make recommendations to the Office of the Deputy Commissioner regarding field operations issues identified in case record/report reviews. Senior staff from the Deputy Commissioner's Office will continue to attend PAC meetings and be responsible for follow through on PAC recommendations related to field operations.
4. Continue PAC's involvement in the development of Department policies. PAC members will continue to review and provide feedback on all Department draft policies, not just those developed from recommendations of the PAC.
5. Continue to serve as the Advisory Committee for the Children's Justice Act Grant.

GOAL 17: TO MAINTAIN A PROFESSIONAL ADVISORY COMMITTEE FOR THE
PURPOSE OF GIVING PROFESSIONAL ADVICE TO THE COMMISSIONER
ON CASE PRACTICE, RESOURCES AND CHILD PROTECTIVE ISSUES
(cont'd)

FY'92 AND FY'93 GOALS:

1. The PAC will continue to meet quarterly to review randomly selected case records and all CIU reports and to advise the Commissioner regarding case practice and policy issues.
2. Subcommittees will continue to meet at least quarterly; however, topics may change or subcommittees may be added as new issues are identified.
3. Continue to make recommendations to the Deputy Commissioner regarding field operations issues identified in case record/report reviews.
4. Continue to maintain a multidisciplinary membership in order to ensure that case record/report reviews are comprehensive and that recommendations made address all issues important and relevant to the provision of adequate and appropriate services.
5. Continue to act as consultant to the CIU staff during investigations.

GOAL 18: TO CONTINUE A CENTRAL OFFICE CONSUMER ACTION OFFICE

During the past year, the Consumer Action Office of the External Relations Division continued to perform its stated function: to assist consumers of service and their advocates by responding to DSS programs, policies and delivery of service; to monitor the content of consumer contacts for any patterns of systemic weakness; and to submit observed patterns, along with recommendations for change to Executive Staff, External Relations, and other staff as appropriate.

Consumers' calls continued to focus on the subjects that have traditionally been brought to the attention of this office: protective issues, foster care, adoption and adolescent issues continue to constitute the majority of calls. A significant number of calls on protective issues concerned child abuse/neglect reports filed by estranged couples involved in custody disputes. Also, a large number of protective issue calls concerning questions from people involved as perpetrators in child abuse reports, who wanted to know how to avail themselves of appeal procedures. Reports of child abuse and neglect received by the Consumer Action Office increased considerably during the year, as did requests for information on obtaining copies of 51A and B materials.

Another area in which there was considerable activity was among foster parents seeking redress of payment problems. The Payment Assistance Line, which was established to address this need, completed its third year of operation

GOAL 18: TO CONTINUE A CENTRAL OFFICE CONSUMER ACTION OFFICE
(cont'd)

during FY'90. In order to share observations and experiences concerning foster parent payment issues, and to obtain current information on various aspects of the foster care program, a representative of the Consumer Action Office was asked to join the Central Office Foster Care Group, which meets bi-monthly. Calls from the foster parent population to the Consumer Action Office Payment Assistance Line increased generally during the year, due in large part to general uncertainty over the states fiscal situation and its possible impact on foster care funding.

GOAL 19: TO CONTINUE THE CASE INVESTIGATION UNIT AS A POLICY DEVELOPMENT COMPONENT FOR THE CENTRAL OFFICE

The Case Investigation Unit (a subdivision of the Office of Professional Services), located at Central Office, conducts Child Fatality Investigations on deaths of children who are either in the care and/or custody of DSS or have been involved with DSS within six months prior to their deaths. The purpose of the investigation is to review the circumstances surrounding the child's death and to determine if the services provided by the Department were appropriate and in compliance with Departmental regulations. In 1989, there was a 22% increase in child fatalities from the previous year. The increase was entirely due to a rise in infant deaths. Partly because of this alarming increase, the Case Investigation Unit has instituted a number of initiatives: All child fatality referrals are being entered into a computerized database with limited access. Referral notices once handled manually are now generated electronically, with standardized information. In addition, collection of these data will allow DSS to routinely and accurately track case referrals through the investigative systems and to monitor trends by allowing analysis of the child death data (e.g., changes in SIDS or substance abuse-related deaths). To increase the specificity of cause of death for DSS cases, the Department of Public Health has been consulted and is supplying death certificate information

GOAL 19: TO CONTINUE THE CASE INVESTIGATION UNIT AS A POLICY
DEVELOPMENT COMPONENT FOR THE CENTRAL OFFICE
(cont'd)

as needed. The Research Unit, also in the Office of Professional Services, is planning to do the analysis on CIU data, beginning with 1989 infant deaths.

The CIU staff continue to work closely with the Professional Advisory Committee in terms of implementing practice and policy recommendations arising from Child Fatality Investigations. CIU staff attend all PAC Meetings. In addition, the CIU has recently instituted a policy whereby PAC members are consulted on all Child Fatality Investigations and their comments are included in the narrative of the Child Fatality Investigations.

GOAL 20: TO CONTINUE THE DEVELOPMENT OF THE DSS COMPUTER SYSTEMS

The Office for Systems met all goals stated in the FY '90 plan. These were:

1. Full implementation of the Partnership Agency Services (PAS) project.

In FY'90 we installed personal computers, printers, and modems at 18 new agency sites. We also provided telecommunication linkage and technical support to 27 additional sites using their own PC equipment. Thirty-three additional agencies were trained to enter data into ASSIST at DSS Area Offices. Initial training and ongoing support has been provided to all PAS sites. This total effort now allows DSS to capture uniform data on all consumers, whether serviced by DSS area offices or by contracted providers.

2. Portable Laptop Personal Computer Pilot Project.

In FY '90 DSS acquired portable laptop personal computers to be used by its social work staff. Preformatted casework forms were developed, enabling social workers to pull up a form on the computer, fill it out, store it on a diskette, and print it whenever necessary.

The Department of Social Services' Family Life Center and selected area offices were used to pilot this project. It was so successful that it will be expanded to a statewide project in FY '91.

3. Develop a comprehensive ASSIST user manual.

In FY '90 the Office for Systems produced a comprehensive user manual that provided detailed instructions for using all data entry and inquiry functions for the 5 components of ASSIST. It features color-coded sections, a user-friendly format, and crisp lay-out and design. We received many favorable comments on its usability from both DSS and Partnership Agency Services staff.

In addition we revised and reformatted the Electronic Mail Service manual to similarly upgrade its usability.

GOAL 20: TO CONTINUE THE DEVELOPMENT OF THE DSS COMPUTER SYSTEMS
(cont'd)

4. Develop a payment mechanism for Miscellaneous Services.

The Office for Systems developed an easy-to-use payment mechanism to reimburse individuals who provide certain specialized services. Miscellaneous Services provides:

- o reimbursement for providing AIDS respite;
- o reimbursement for providing respite provided on an exchange basis;
- o reimbursement for providing special services to children who live in the homes of other foster families;
- o stipends for foster and adoptive parents' participation in training;
- o lump sum payments for foster parent insurance costs;
- o payment for developmentally disabled children who are receiving services requested by their parents and paid for through a sliding fee schedule
This payment mechanism proved to be flexible enough to allow the addition of 4 more types of payment:
- o payment for emergency clothing for children in placement;
- o a stipend for expenses incurred by Parent Aide Volunteers who assist in keeping high risk families intact;
- o payment for groups of adolescents in family-based residences where they are taught independent living skills;
- o a flexible payment method for other "miscellaneous services" that don't fit into other payment mechanisms;

GOAL 20: TO CONTINUE THE DEVELOPMENT OF THE DSS COMPUTER SYSTEMS
(cont'd)

5. Support the structural reorganization of DSS.

In order to more efficiently and economically use staff and resources, DSS eliminated 6 regional offices and consolidated 45 area offices into 26 areas. The Office for Systems developed and implemented a new ASSIST numbering scheme for identifying offices and staff. This ensured the continued accurate functioning of ASSIST by having continuity of case assignments, contract distributions, placement authorizations, etc.

6. Support the Title IV-E Revenue Enhancement Project.

The Office for Systems extrapolated data from ASSIST to support efforts to maximize federal reimbursement for children in substitute care placements.

7. Support the DSS goal of continuing to improve its working relationship with the district attorneys under Chapter 288.

The Office for Systems developed programming necessary to automatically generate a letter every 6 months to each DA who received a DSS referral under Chapter 288. The letter requests that the DA notify DSS concerning action taken on each referral.

8. Consolidate major reports.

The Office for Systems consolidated and simplified ASSIST tickler reports used by direct service staff. We also greatly reduced the number of reports received by area offices and PAS agencies.

For FY '91 the Office for Systems has the following goals for the development of the ASSIST system:

1. To Automate the Area Offices with Personal Computers, Portable Laptop Computers, and CPT Word Processors.

GOAL 20: TO CONTINUE THE DEVELOPMENT OF THE DSS COMPUTER SYSTEMS
(cont'd)

In FY '91 we will oversee the installation of this equipment; provide training on its use to social work, managerial, and clerical staff and assist with applications. This will support staff in maximizing their time and will streamline the documentation tasks of social workers.

2. To Develop Customized PC Software Applications To Meet The Needs of Area Offices.

Four mainframe computer programmer-analysts will be crosstrained on PC software programming. They will then develop applications tailor-made to the requests and specifications of Area Office Staff. For example, a program to calculate the sliding fee amount for a family receiving services, or an easy-to-update list of resources for Information and Referral purposes might be programmed.

3. To Expand The Laptop Personal Computer Project Statewide.

In FY '91 we will acquire additional laptop computers for DSS service delivery offices. Many casework forms will be formatted on disks by the Office for Systems, and distributed to Area Offices. The Office for Systems staff will also provide training.

4. To Create A Systems Information Center to Respond to the Immediate Needs Of ASSIST Users.

An Office for Systems' staff person will be available each day to solve user problems with applications as well as with equipment, to investigate and correct possible programming bugs, and to solve access issues. In addition, the Information Center representative will perform certain security functions such as deleting duplicate consumer registrations. The Information Center will respond to both DSS and contracted private social service agency staff.

5. To Create a Court Activity Event for DSS Staff Attorneys. An event and accompanying reports will be designed to aid DSS attorneys in the timely processing of all custody actions and all other related

GOAL 20: TO CONTINUE THE DEVELOPMENT OF THE DSS COMPUTER SYSTEMS
(cont'd)

court activities. This will support efficient movement through the legal system for the children DSS serves.

6. To Make Case Activity Information Available On-line.

By making information on case activities due available on-line as well as in report format, we will assist the social work staff in meeting health care appointments, case reviews, and other events in a timely manner.

GOAL 21: TO CONDUCT A FOSTER CARE RECRUITMENT CAMPAIGN

The Department of Social Services' ongoing foster care recruitment campaign, begun in January, 1986, continues to promote a variety of activities to support foster parent recruitment and recognition and public education concerning foster care. As of June, 1990, there were 6,352 foster homes compared to 4,400 in FY'85. This 1,952 increase is significant not only for the net increase but also reflects our ability to retain existing foster parents through an aggressive recruitment/retention campaign. This is at a time when a majority of states nationwide are evidencing tremendous reductions in their number of foster homes.

Various area offices found different recruitment techniques helpful. For example, in Springfield, 48 families completed the MAPP training program as a result of community/church networking and the efforts of the Springfield Hispanic Foster Parent Association; in Worcester 40 families completed MAPP and were approved as new family resources from a combination of activities including newspaper ads, word of mouth and the 'One School, One Child' program; from January to July, 1990 stemming from veteran foster parent informal outreach promoting the foster care program at weddings, bingo, summer picnics, etc., the Fitchburg area office has recruited seventeen MAPP enrollees (including three child specific families interested in becoming regular foster homes) plus saw thirteen families graduate from MAPP and in FY '91, they are beginning to follow up on an additional 113 inquiries; in Brockton, nineteen prospective foster parents attended MAPP training in January, 1990 and twenty-four families attended MAPP training in April, 1990 largely as a result of special newspaper ads and child specific/foster care recruitment articles; in Boston's Solomon Carter Fuller area office an assertive recruitment effort resulted in the graduation of 19 Hispanic families from MAPP training in the spring.

As of June, 1990, 9,360 children across the Commonwealth were in foster care, a 19% increase over this time last year. It is generally agreed that these increases are due to the escalating use of cocaine and other drugs and their effects on the ability of families to care for children. The Boston area in particular has been greatly impacted by this situation.

As a result, the Department of Social Services, along with the Massachusetts Association for Professional Foster Care as an active partner, began the multi-faceted "Boston Blitz," a major foster family recruitment campaign aimed at Boston/Brookline areas. From May 1 through July 15, 1990, intensive recruitment efforts resulted in over 180 inquiries from Boston and surrounding areas responding to the urgent appeal and over 50 families completing MAPP training.

Goal 21: To Conduct A Foster Care Recruitment Campaign (cont'd.)

The program's efforts continue to receive national recognition; from 1987 to the present we have experienced four years of achievement: in 1987, the Department received the National Foster Parent Association 'State Agency of the Year' award for foster parent recruitment and training; in 1988, we received the American Public Welfare Association's 'Successful Projects Initiative Award' for our foster parent recruitment campaign; in 1989, the United States General Accounting Office Report to Congressional Requestors highlighted the Department for effective foster parent recruitment and preservice training; in 1990, the Council of State Governments 'Innovations' program selected the DSS foster parent recruitment campaign as a semi-finalist in the Eastern region (finalists will be announced in November); and in 1990 the Department received the National Foster Parent Association 'State Agency of the Year' award for our foster parent program for the second time in three years!

We continue to be contacted by public and private child welfare agencies from states across the nation who wish to emulate our campaign and its successful innovations: Professional Parent Newsletter, unique partnership developed between foster parents and the Department, Foster Parent Recruitment Handbook used as a guide in developing recruitment strategies and the variety of innovative activities we have created to further foster home recruitment/retention/recognition.

Our goals for FY'91 and beyond include ongoing efforts in two important areas:

0 Give support to the Field Support and Area Offices in their foster care recruitment/retention/recognition initiatives.

0 Reach out to the general community to present a consistent and positive image of foster care and to encourage persons from each of the Commonwealth's 351 cities and towns to consider foster parenting. At the same time, we need to promote awareness and education within the community at large concerning the diverse population of children now coming into care whether it be the drug addicted infant, HIV infected toddler, teenager, sibling group, child with special needs, etc. The better our recruitment needs are understood and the larger the pool of foster families, the better able we are to match children to the home most suitable for their situation.

Goal 21: To Conduct A Foster Care Recruitment Campaign (cont'd.)

Our campaign will continue to include the following components: Foster Care Recruitment material development, media efforts, community outreach, significant recruitment/appreciation events.

1. Public Information Materials

During FY'91 and beyond we will develop and produce more of the following materials which have been effective in foster care recruitment and appreciation:

Existing Materials

- 0 T-Shirts
- 0 Bookmarks
- 0 Brochures in English and Spanish
- 0 Canvas Bags
- 0 Foster Parent Recruitment 1991 Calendar
- 0 Posters/flyers in English and other languages
- 0 Professional Parent Quarterly Recruitment and Training Newsletter

2. Media Initiatives

The Office of Public Affairs and the Statewide Foster Care Recruitment Task Force, through the award of a Boston Globe Foundation Grant produced a 30 second Foster Parent Recruitment Public Service Announcement that will broadcast during the first half of FY'91 on the following major television stations: WNEV, WBZ, WCVB, WLVI. During the second half of FY'91 and beyond, we will begin to show the PSA extensively on cable television stations. During FY'90, a professional foster care recruitment video entitled, "Families Helping Families" was produced with a Special Projects Grant, conceived by the Statewide Foster Care Recruitment Task Force. The completed video was distributed to all area offices and will continue to be used during FY'91 and beyond to accompany presentations on foster care given by Family Resource Staff and will also be shown extensively on cable television. Both the PSA and video are flexible, multi-purpose tools to enhance public awareness and provide the public with information regarding all aspects of the Department's foster care program and recruitment needs.

Throughout FY'90, radio and cable TV PSA's and foster parent profiles, newspaper ads, newspaper profiles of foster parents and foster children and press releases were sent out to stations/newspapers statewide from the Public Affairs Office as well as from Area and Field Support Offices to announce special foster care events and to continue to interest the public in foster parenting. For example, Channel Seven, WNEV-TV ran a week-long series in October, 1989 on the topic 'Drugs and Newborns' and highlighted the need for foster care for young drug addicted children. The station ran our Foster Parent Recruitment Line and we received over 100 phone calls from prospective foster parents.

Goal 21: To Conduct a Foster Care Recruitment Campaign (cont'd).

These efforts will continue in FY'91 and beyond to keep our recruitment message visible. In addition, we will continue our efforts with two very innovative child specific media programs. The WBZ TV-4 Boston National Award Winning Program "Wednesday's Child" hosted by Jack Williams and Springfield's WWLP TV-22 "Today's Child" Program hosted by Dave Madsen both provide outstanding foster parent profiles.

3. Community Outreach

During FY'90, the Department continued its efforts with school systems statewide to continue to educate students, teachers and parents about our foster care program. A foster care recruitment video was produced by students of the Communications Arts/Television Production Class of the Madison Park/Humphrey High School, Boston, during September to November and distributed for area office use. This video, an effort of the Statewide Foster Care Recruitment Task Force will continue to be used by area offices during FY'91 as part of their foster care education efforts with the schools.

During FY'91, the Department will receive the continued support of major religious affiliations who assisted us in FY'90 and who will help us with our FY'91 recruitment efforts. A foster care recruitment packet including sermon tips, prepared article and camera ready flyer for church/temple bulletins will be sent to some 500 churches/temples and in addition these parishes and dioceses will replicate our mailing to send to each of their member churches involving some one to two thousand additional parishes receiving our foster care information packet.

In addition, we will contact the many supermarket chains who participated in our recruitment efforts in FY'90, for their continued support in FY'91. During FY'90 over 20 members of the Massachusetts Food Association (most major supermarket chains) ran our foster care message in their stores statewide on their bags, circulars, and as bag stuffers. For example, Demoulas/Market Basket placed our foster care recruitment flyers in 39 of their stores statewide and was responsible for printing the quantity needed and the distribution. We expect this same cooperation during FY'91 from the Massachusetts Food Association members.

Field Support and Area Offices will continue to conduct a variety of recruitment and appreciation activities throughout FY'91 to promote community outreach: recruitment booths at malls, post offices, and libraries; information nights at various community organizations and schools; displaying and distributing flyers/posters/bookmarks in key community spots; picnics/potluck suppers.

Goal 21: To Conduct A Foster Care Recruitment Campaign (cont'd.)

4. Foster Parent Recognition Events

During the month of May (foster parent month), our FY'91 efforts will culminate in the 6th Annual Foster Parent Recognition Event, hosted by the Massachusetts Association for Professional Foster Care. Outstanding foster families from across the state will be honored along with some private agency foster parents.

During the months of April, May and June Department Area and Field Support Offices will conduct their own appreciation events in order to insure that all foster families statewide participate in events that honor their important contribution to the troubled children and families of the Commonwealth.

During the months of April, May and June the Department's Field Support Offices and also some Area Offices will conduct their Annual Spring Institutes for foster parents which combine recognition activities with workshops.

Our appreciation events coupled with our quarterly newsletter, foster parent support groups and other projects help to maintain foster parent retention by providing foster parents with the recognition, education, and support they deserve. In turn, this gives them the incentive to keep up their dedication to foster parenting.

5. General Public Training

A. Child Abuse Prevention Campaign

In FY'90, the Department began a new "Don't Shut Your Eyes To Child Abuse" campaign aimed at the general public. Major supermarket chains ran our child abuse prevention flyers and during FY'91 and beyond this effort will continue to include churches/synagogues and other organizations. In addition to child abuse prevention flyers, we will also produce child abuse prevention posters.

The Veterans of Foreign Wars joined our Child Abuse Prevention Campaign by conducting a major fundraising effort which yielded \$39,000 which the VFW donated to the Department to use for FY'91 infant and toddler foster care placement packets. When infants and toddlers enter foster care, the foster parents will receive a placement packet of items (infant formula, teethingers, diapers, etc.) that will make the initial adjustment to foster care easier for the child and the foster parents who care for them. Placement packets will also be produced for all age children entering foster care in FY'91 and beyond. The placement packet project is also part of our foster parent retention efforts and community outreach. A number of companies have donated items for use in the placement packets from Gerber Products, Michigan to Hasbro Toys, Rhode Island to Pilgrim Infant Products, Fitchburg, MA.

Goal 21: To Conduct A Foster Care Recruitment Campaign (cont'd.)

B. Positive Parenting Campaign

This summer, the start of FY'91, the Department of Social Services began a new campaign to further community awareness about the importance of positive parenting. The Department wishes to encourage families to learn more about constructive parenting techniques that will help them create a harmonious family atmosphere for themselves and their children. Similar to our ongoing foster parent recruitment and child abuse prevention campaigns, the Department will work through the schools, hospitals, churches/synagogues, send out radio/TV public service announcements as well as use other means to get the new parent awareness message out to Massachusetts families. For example, Positive Parenting flyers in English and Spanish were sent to all the public and private schools throughout the Commonwealth for distribution to students and the Massachusetts Hospital Association will distribute the flyers for us at their member hospitals. To accompany the print campaign on Positive Parenting, we are planning to create several Positive Parenting PSA's for television.

C. Mandated Reporter Efforts

During FY'90, the Department engaged in the following Mandated Reporter efforts, which will be continued in FY'91 and beyond.

Outreach regarding mandated reporting has been conducted at the area office, field support and central office levels.

Area offices continue to meet with local schools, hospitals, day care centers, etc., based upon request and/or need. Screening and investigative personnel meet directly with the mandated and non-mandated reporter groups.

Field support offices in conjunction with the Office of Professional Services continue to conduct large scale statewide trainings. For example, training was made available to all District Court probation officers; local police officers were trained to become "master trainers" in our ongoing attempt to institutionalize mandated reporter education and all day care voucher management agency representatives received training.

On the central office level, the Office of Public Affairs (OPA) rewrote guidelines to reflect recent changes in the law. Our educational brochure was updated and is being printed in English and Spanish. We are working cooperatively with the Board of Registration to access reporters through license application and renewal. In addition, we are developing contacts with private sector agencies to enlist their cooperation and resources. The Office of Public Affairs continues to process referrals and disseminate materials upon request.

GOAL 22: TO IMPROVE SERVICES TO LINGUISTIC AND ETHNIC MINORITIES
THROUGH THE MINORITY ISSUES COORDINATING GROUP AND THE
STATEWIDE MINORITY COUNCIL

The Department has developed the "Enhancing Cultural Competency Initiative" which specifically outlines the components in the D.S.S. service delivery system which can be utilized/expanded to improve services to ethnic and linguistic minority staff and consumers. Currently, the following goals set forth in the initiative are being met:

- o Training - The Department provides a diversity of training sessions focusing on cultural sensitivity/awareness topics to increase staff capacity to work with families across cultures.
- o Translations - The Department ensures that all consumer-oriented materials are translated into the languages in highest demand.
- o Affirmative Action - The Department maintains an outstanding record in the recruitment and employment of minority staff at all levels of the agency.

The Department of Social Services has been a model for successful implementation of the Commonwealth's MBE program. In its MBE plan the Department outlines a series of incentives for minority vendors including the following:

- o Entire bids or portions of bids set aside for minority vendors.
- o Minority vendors are automatically included in the final proposal review process and receive additional points or other types of positive valuation in the review process.

GOAL 22: TO IMPROVE SERVICES TO LINGUISTIC AND ETHNIC MINORITIES
THROUGH THE MINORITY ISSUES COORDINATING GROUP AND THE
STATEWIDE MINORITY COUNCIL (cont'd)

- o Subcontracts or other types of joint ventures are encouraged and receive additional points in the review process.
- o Spin off projects where a non-minority vendor works with a minority vendor for a period of time until the MBE can deliver the program on its own is encouraged.

Application of these principles was integral to the Department's creation of Commonworks Networks; an initiative through which the Department significantly increased its capacity to provide services to troubled youth. "Networks", comprised of minority and non-minority providers, offer staff secure diagnostic and assessment services, staff treatment services, transition to independent living, foster care and tracking. Commonworks was made possible through spin-off and other joint ventures between the minority and non-minority providers. Minority vendors were able to enter new areas of service delivery with the support and technical assistance of experienced providers. Non-minority providers also benefited from this collaboration by learning how to better approach and serve minority consumers.

The remaining goals set forth in the "Enhancing Cultural Competence Initiative" which the Department is committed to achieving and which constitute a priority include:

GOAL 22: TO IMPROVE SERVICES TO LINGUISTIC AND ETHNIC MINORITIES
THROUGH THE MINORITY ISSUES COORDINATING GROUP AND THE
STATEWIDE MINORITY COUNCIL (cont'd)

- o Enhancement of specialized foster care recruitment activities to meet the needs of ethnic/linguistic populations.
- o Creation of annual and quarterly reports to answer demographic questions regarding the size, age, legal, placement and service plan status of ethnic/linguistic populations.
- o Utilization of the DSS Update and the Professional Parent to highlight ethnic/linguistic consumer/staff issues and concerns.
- o Ongoing evaluation of existing efforts to allow for corresponding programs and needs.

A major goal of the "Enhancing Cultural Competency Initiative" is to restructure the Department's Statewide Minority Council so that this group can more effectively function in an advisory capacity to the administration on issues relevant to minority consumers and employees. The Council has drafted a "historical statement" offering a perspective on the development and activities of the Council to date. The Council has also developed a position paper detailing possible goals for FY'91-93.

Proposed activities include:

- o Collaborating with the Department's Office of Public Affairs to conduct recruitment of foster and adoptive families.
- o Aiding in developing and evaluating programs and services in communities of color.

GOAL 22: TO IMPROVE SERVICES TO LINGUISTIC AND ETHNIC MINORITIES
THROUGH THE MINORITY ISSUES COORDINATING GROUP AND THE
STATEWIDE MINORITY COUNCIL (cont'd)

- o Participating on the Foster Care Recruitment Task Force.

The Council is also developing a Mentoring Program.

Through the mentoring program experienced minority workers will be paired with new workers in a buddy system to make them feel welcome, acquaint them the agency, and provide emotional support.

GOAL 23: TO PROVIDE TRAINING TO DSS EMPLOYEES AND FOSTER PARENTS THROUGH THE TRAINING INSTITUTE

For FY 90 the goals of the Training Institute were surpassed. The Pre-Service Program ran 10 times (compared to seven in past years). The Pre-service program was revised to reflect current trends in the caseload, particularly drug and alcohol abusing families, and to address issues of family violence. The program began to run monthly in January so that groups would be smaller in size. This year over 450 social workers completed the program.

One hundred in-service training programs were projected for the year. One hundred and forty two courses were run including eighteen social worker safety courses (two day curriculum), five drug and alcohol courses (three day curriculum), three writing courses (four day curriculum), five rounds of supervisory training (eight day curriculum), one round of management training (eight day curriculum), two rounds of investigations training (eight day curriculum), and one hundred and six in-service workshops (see attached list of all Social Work Institute courses).

During FY90 there were 119 Family Resource trainings conducted across the state with total attendance just under 2500 for the year. DSS continued its implementation of the MAPP, Massachusetts Approach to Partnerships in Parenting, a thirty hour pre-service training program for foster parents. This year 99 MAPP training programs were completed with approximately 1400 participants.

GOAL 23: TO PROVIDE TRAINING TO DSS EMPLOYEES AND FOSTER PARENTS THROUGH THE TRAINING INSTITUTE (cont'd)

The Department will continue its training through the Social Work Training Institute, the Family Resource Training Institute, and Professional Development Programs. A goal of the unit will be to make trainings, particularly drug, alcohol, and family violence related trainings, more accessible to staff. The Family Resource Institute will seek to increase foster parent involvement in training through implementing more in-home training opportunities (i.e. workbooks, videos). In addition the MAPP curriculum will be revised to reflect changing needs of our children including medically involved children, AIDS information, and adolescent issues. The implementation of the new curriculum will take place throughout the year. Efforts will continue to have all supervisors attend the eight day supervisory pre-service curriculum (by the end of FY92 over 300 supervisors will be trained).

By FY 92-93 the Department will need to review all pre-service training programs including supervisory, management, family resource, social worker and investigations. Revision (similar to MAPP revision during FY92) will be implemented throughout the course of the year. Efforts will continue to find creative ways to involve foster parents in training--through both increased in-home

GOAL 23: TO PROVIDE TRAINING TO DSS EMPLOYEES AND FOSTER PARENTS
THROUGH THE TRAINING INSTITUTE (cont'd)

opportunities and increased professional development. As all supervisors will have completed the Supervisory eight day curriculum, a training program which meets their on going needs will be developed.

TRAINING ACCOMPLISHMENTS FY 90: SUMMARY

TITLE	# COURSES	TOTAL DAYS	TOTAL PARTICIPANTS
SOCIAL WORK INSTITUTE			
Social Worker Safety	18	33	325
DPH: Drug & Alcohol (Sups)	5	15	119
Writing: Eng. as a 2nd Lan.	3	12	28
FSU Administrative Training	2	2	60
Pre-Service for S.W.	10	96	465
Sup/Man Pre-Service Pilot	6	48	90
Investigations Training	2	16	36
S.W. Institute In-Service	106	130	1,616
S.W. INSTITUTE TOTALS:	152	352	2,739
PROFESSIONAL DEVELOPMENT			
Conference Reimbursement	-	-	389
Tuition Reimbursement	-	-	260
Tuition Remission	-	-	536
BHRD Tier Programs	-	-	20
Educational Leave	-	-	21
CPCS Program	-	-	49
PRO. DEVEL. TOTAL			1,275
FAMILY RESOURCE INSTITUTE			
Institute Courses	113	(approx. 113)	1,841
Spring Institutes	4	4	505
Fam. Res. Sups. Day	2	2	80
FAM. RES. INSTIT. TOTAL	119	119	2,426
OTHER			
APM Meetings	2	2	105
AD Conference	1	2	65
AD Meetings/Trainings	10	10	550
Judicial Conference	1	1	35
OTHER TOTALS:	13	14	755
<u>TOTAL TRAINING</u>	284	485	7,195
	COURSES/EVENTS	DAYS	(6,920 Training Part. 1,275 Pro. Dev. Part.)

Family Resource Training Institute

FY 1990 Courses Held

August 1989

<u>Course</u>	<u>Where</u>
1. Preparing Adolescent for Young Adulthood	New Bedford
2. Preparing Adolescent for Young Adulthood	New Bedford
3. Preparing Adolescent for Young Adulthood	New Bedford

September 1989

4. Family Res. Pre-Service (Family Systems)	Boston
5. Building Self-Esteem	Salem State

October 1989

6. Behavior Management	Cambridge
7. Stages in Adoptive Relationship	Springfield
8. Preparing Children to Move, Reattach, Belong	Springfield
9. Mediation Training	Holyoke (n)
10. Working With Narcotic and Cocaine Addicted Babies	
11. Treatment Considerations in Foster Care	Boston
12. MAPP Leader Training	Framingham
13. How to Communicate with Your Teen	Malden
14. Family Resource Pre-Service, Infertility, Recruitment	

November 1989

15. MAPP Leader Training	Boston
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(n)= night

CourseWhereNovember

16. 766 Training	Brockton
17. Adolescent Sexuality	Holyoke
18. Cultural Considerations in Placement	Boston
19. Family Violence	Brockton
20. CPR Training	Haverhill (n)
21. CPR Training	Haverhill (n)
22. Loss Issues in Adoption	Holyoke
23. Stress Management	Worcester
24. Foster Parenting Sexually Abused Children	Lynn
25. Legal Aspects of Foster Care & Adoption	Lawrence
26. Clinical Considerations in Open Adoption	Lowell
27. Talking to Children About Adoption	Brockton
28. Strategic Planning for Family Res. Sups.	Framingham
29. Family Resource Pre-Service Life Book/ Group Work	Worcester
30. Family Resource Pre-Service Foster Family Adoption	Worcester
31. AIDS Training	Brockton (n)

December

32. AIDS Training	Brockton
33. Mediation Skills	Boston

January

34. Working W/ Narc. & Cocaine Addicted Babies	Lowell
35. How to Assess Foster Parents for Adoption	Boston

(n)= Evening

36. Foster Parenting Sexually Abused Children	Malden
37. Cultural Considerations in Placement	Lowell
38. Understanding Substance Abuse	Cambridge

February 1990

39. CPR Training	Fall River
40. Behavior Manag. w/ Sexually Abused Children	Pittsfield
41. MAPP Problem Solving	Needham
42. MAPP Problem Solving	Sturbridge
43. PACT	Framingham
44. How to Communicate with Adolescents	Webster
45. Adolescent Suicide	Malden
46 Adolescent Development Issues	Cambridge
47. As others See Us: Foster Parents & the Community	Framingham
48. Introduction to Group Work	Worcester
49. PAYA Training	Pittsfield
50. Family Resource Pre-Service Attachment/Separation	Boston
51. PAYA Training	
52. Behavior Management	Quincy

March 1990

53. Behavior Management	Lawrence
54. MAPP Leader Training	Boston
55. Adolescent Sexuality	Malden
56. Foster Parenting Sexually Abused Child	New Bedford

March 1990

57. Behavior Management (Spanish)	Alianza Hispana
58. Effects of Foster Care on the Family	Brockton
59. Search	Holyoke
60. Behavior Manag. w/ Sexually Abused Children	Pittsfield
61. MAPP Leader Training	Boston
62. MAPP Leader Training	Framingham
63. MAPP Leader Training	Lakeville
64. Working With Narcotic & Cocaine Addicted Babies	Worcester
65. Mediation Skills	Lakeville
66. Self-Esteem Training	Salem State
67. Family Resource Pre-Service Reg. Policy/Disruption	Boston
68. Family Resource Pre-Service Adoption Overview	Worcester
69. HIV & Addicted Children	Fitchburg
70. PAYA Training	New Bedford
71. PAYA Training	New Bedford
72. PAYA Training	New Bedford
73. Sexual Abuse	Waltham

April

74. Behavior Management	Holyoke
75. Care and Feeding of Support Groups	Boston
76. Behavior Management with Sexually Abused Kids	Pittsfield
77. Advanced Group Work	Boston
78. Effects of Foster Care on the Family	Quincy
79. Behavior Management	New Bedford

April 1990

80. Understanding Sexual Abused	Jamaica Plain
81. Effect of Foster Care on the Family	Webster
82. Coping with Anger & Loss (Spanish)	Lawrence
83. AIDS and Grieving	Holyoke
84. As Other See Us: Foster Parents & Community	Quincy

May

85. The Adolescent Adoptee: A Time of Turmoil	Worcester
86. Building Self-Esteem	Salem State
87. Clinical Considerations in Open Adoption	Worcester
88. Adolescent Sexuality	Attleboro
89. Understading 51 A's	New Bedford
90. Behavior Management (Spanish)	Springfield
91. Behavior Management (English)	Dorchester
92. Family Resource Sups: Stress Management	Boston
93. Adoption Training for Foster Parents	Pittisfield
94. Foster Families and Adoption	Boston
95. Working with Narcotic and Cocaine Addicted Babies	Springfield
96. Family Violence	Webster
97. Foster Parenting Sexually Abused Children	Brockton
98. The Therapist as a Team Member	Quincy
99. Legal Aspects of Foster Care and Adoption	Boston
100. Origin, Culture & Racism (Spanish)	Holyoke

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
Addressing Homeless Issues in the Ongoing Caseload	04/20/90	5.0	32	32	27
		-----	---	---	---
		5.0	32	32	27
Adolescent Assessment	06/25/90	5.0	12	12	16
		-----	---	---	---
		5.0	12	12	16
Adolescent Counseling	04/18/90	5.0	38	38	17
		-----	---	---	---
		5.0	38	38	17
Adolescent Development Issues in Placement	02/07/90	3.0	2	2	2
	06/13/90	3.0	10	10	10
		-----	---	---	---
		6.0	12	12	12
Adolescent Developmental Issues	03/06/90	3.0	4	4	4
		-----	---	---	---
		3.0	4	4	4
Adolescent Sexuality	11/02/89	3.0	12	12	8
	03/08/90	2.5	5	5	9
		-----	---	---	---
		5.5	17	17	17
Adolescent Substance Abuse	03/02/90	5.0	24	24	17
		-----	---	---	---
		5.0	24	24	17
Adolescent Suicide	01/23/90	4.5	21	21	10
	02/07/90	3.0	13	13	18
		-----	---	---	---
		7.5	34	34	28
Adolescents and HIV Infection	05/21/90	5.0	10	10	13
		-----	---	---	---
		5.0	10	10	13
Adult Children of Alcoholics	10/13/89	5.0	24	24	19

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDING
		5.0	24	24	19
Advanced Group Work Skills	04/19/90	12.0	16	16	11
		12.0	16	16	11
Advanced Worker Safety	05/30/90	5.0	6	6	6
	06/05/90	5.0	0	0	5
	06/13/90	5.0	10	10	10
		15.0	16	16	21
Aids Information Workshop	03/15/90	3.5	6	6	4
		3.5	6	6	4
Alcohol and Drug Addiction	04/19/90	10.0	21	21	7
		10.0	21	21	7
APM QUARTERLY MEETING	06/21/90	5.0	52	52	49
		5.0	52	52	49
APM Statewide Meeting	03/15/90	5.0	56	56	56
		5.0	56	56	56
As Others See Us: Foster Parents and the Community	02/05/90	2.5	18	18	18
	04/23/90	2.0	0	0	6
		4.5	18	18	24
Assessing & Treating the Neglecting Family	02/15/90	15.0	37	35	18
		15.0	37	35	18
Assessment Training	06/11/90	18.0	23	23	19
		18.0	23	23	19
Assessment Training in Child Welfare	06/25/90	17.0	35	35	35

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
		-----	---	---	---
		17.0	35	35	35
Barriers in Supervision					
	10/24/89	5.0	8	8	8
	03/23/90	5.0	14	14	11
	03/30/90	5.0	11	11	12
	06/14/90	5.0	13	13	6
		-----	---	---	---
		20.0	46	46	37
Behavior Management					
	10/03/89	3.0	16	16	11
	02/28/90	3.0	21	21	9
	04/11/90	3.0	1	1	24
	05/09/90	3.0	6	6	3
		-----	---	---	---
		12.0	44	44	47
Borderline Personalities					
	04/05/90	10.0	58	27	10
		-----	---	---	---
		10.0	58	27	10
Building Self-Esteem in Children in Placement					
	09/26/89	15.0	10	10	10
		-----	---	---	---
		15.0	10	10	10
Care and Feeding of Foster Parent Support Groups					
	04/06/90	5.0	1	1	9
		-----	---	---	---
		5.0	1	1	9
Case Recording					
	01/29/90	5.0	14	14	10
		-----	---	---	---
		5.0	14	14	10
Casework with HIV Infected Families					
	04/23/90	5.0	28	28	20
		-----	---	---	---
		5.0	28	28	20
Civil Service Exam Preparation					
	11/27/89	5.0	31	31	24
	11/28/89	5.0	19	19	14
	11/29/89	5.0	35	35	26
		-----	---	---	---
		15.0	85	85	64
Civil Service Exam Prepartation					
	11/07/89	5.0	30	25	22

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEES
		5.0	30	25	22
Clinical Considerations in Open Adoption	11/17/89	2.5	15	15	9
	05/04/90	2.5	10	10	12
		5.0	25	25	21
Coaching and Counseling	10/11/89	5.0	10	10	8
		5.0	10	10	8
Confidentiality in Social Work Practice	02/07/90	2.5	19	19	13
	02/21/90	2.5	6	6	11
	04/18/90	2.5	10	10	7
	06/27/90	2.5	7	7	10
		10.0	42	42	41
Conflict Management	06/06/90	10.0	23	23	15
		10.0	23	23	15
Conflict Management for Area Program Managers	05/01/90	10.0	4	4	16
		10.0	4	4	16
Courtroom Testifying	02/14/90	5.0	25	25	18
	03/07/90	5.0	10	10	15
	06/20/90	5.0	20	20	15
		15.0	55	55	48
Crack, Cocaine and Protective Issues	11/17/89	5.0	27	27	23
	03/09/90	5.0	71	45	37
	06/29/90	6.0	22	22	15
		16.0	120	94	75
Crisis vs. Functional Turmoil	03/08/90	10.0	34	29	23
		10.0	34	29	23
Cross Cultural Interviewing	02/08/90	5.0	24	24	15

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDING
	05/22/90	5.0	8	8	20
		-----	---	---	---
		10.0	32	32	35
Cultural Considerations in Placement					
	11/03/89	3.0	12	12	5
	01/31/90	3.0	12	12	12
		-----	---	---	---
		6.0	24	24	17
Dealing with Change Ourselves					
	12/07/89	5.0	12	12	10
		-----	---	---	---
		5.0	12	12	10
Designing Culturally Sensitive Training					
	09/29/89	5.0	38	38	33
		-----	---	---	---
		5.0	38	38	33
Diagnosis & Treatment of Alcoholism and Drug Abuse					
	01/11/90	11.0	24	24	17
		-----	---	---	---
		11.0	24	24	17
Dual Diagnosis: Clinical Dilemmas					
	01/17/90	5.0	21	21	13
		-----	---	---	---
		5.0	21	21	13
Effective Performance Evaluation					
	10/18/89	5.0	10	10	8
		-----	---	---	---
		5.0	10	10	8
Effective Use of Confrontation					
	10/23/89	5.0	39	25	21
	12/14/89	5.0	23	23	15
	05/17/90	5.0	47	40	23
		-----	---	---	---
		15.0	109	88	59
Effects of Foster Care on the Family					
	03/12/90	2.0	9	9	24
	04/10/90	3.0	16	16	21
	04/12/90	3.0	8	8	13
		-----	---	---	---
		8.0	33	33	58
Essential Writing Skills					
	09/27/89	20.0	10	10	9
	03/20/90	20.0	13	12	11
	06/05/90	20.0	5	5	8

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDED
		60.0	28	27	28
Failure to Thrive					
	10/30/89	3.0	15	15	10
	01/08/90	3.0	8	8	8
		6.0	23	23	18
Family Resource Pre-Service: Adoption Overview					
	03/28/90	5.0	15	15	8
		5.0	15	15	8
Family Resource Pre-Service: Family Systems					
	09/26/89	4.5	19	19	15
		4.5	19	19	15
Family Resource Pre-Service: Foster Families Adopt					
	11/28/89	5.0	17	17	8
		5.0	17	17	8
Family Resource Pre-Service: Group Work Skills					
	11/27/89	3.0	14	14	8
		3.0	14	14	8
Family Resource Pre-Service: Infertility					
	10/24/89	2.5	13	13	9
	10/24/89	2.5	11	11	9
		5.0	24	24	18
Family Resource Pre-Service: Lifebooks					
	11/27/89	3.0	14	14	10
		3.0	14	14	10
Family Resource Pre-Service: Recruitment					
	10/24/89	2.5	9	9	6
		2.5	9	9	6
Family Resource Pre-Service: Regulations and Policy					
	03/26/90	5.0	17	17	8
		5.0	17	17	8
Family Resource Supervisor's Day					
	05/09/90	5.0	28	28	32

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDED
		5.0	28	28	32
Family Resource: Readiness, Attachment, & Belonging	02/26/90	5.0	27	25	10
		5.0	27	25	10
Family Violence	10/06/89	5.0	20	20	16
	01/12/90	5.0	34	25	17
	03/16/90	5.0	54	29	18
	05/17/90	3.0	16	16	22
	06/15/90	5.0	45	45	40
		23.0	169	135	113
Foster Family Adoption	05/15/90	10.0	20	20	25
		10.0	20	20	25
Foster Parenting the Sexually Abused Child	11/13/89	3.0	22	22	16
	01/26/90	3.0	7	7	8
	03/09/90	3.0	9	9	6
	05/21/90	3.0	10	10	7
		12.0	48	48	37
Gangs, Guns and Violence	05/24/90	5.0	94	80	68
		5.0	94	80	68
Grieving Children	06/20/90	5.0	65	50	45
		5.0	65	50	45
Growth Development and Pathology	05/03/90	10.0	38	28	19
		10.0	38	28	19
How the Infertile Couple Decides to Adopt	11/16/89	2.5	6	9	9
		2.5	6	9	9
How to Assess Foster Parents for Adoption	01/12/90	11.0	13	13	13

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDERS
		11.0	13	13	13
How to Communicate with Adolescents					
	10/25/89	2.5	15	15	15
	02/15/90	3.0	6	6	9
	05/23/90	3.0	9	9	6
		8.5	30	30	30
Human Sexuality with a Focus on Adolescence					
	02/27/90	5.0	14	14	7
		5.0	14	14	7
Interviewing Alleged Offenders in Sexual Abuse Case					
	12/12/89	2.5	20	20	17
	05/08/90	2.5	17	17	16
		5.0	37	37	33
Interviewing Alleged Offenders in Sexual Abuse Cases					
	10/24/89	5.0	22	22	17
	11/20/89	5.0	38	28	24
		10.0	60	50	41
Interviewing Children in Child Sexual Abuse Cases					
	01/05/90	5.0	26	26	22
	02/02/90	5.0	39	35	28
	04/13/90	5.0	26	26	18
	05/08/90	2.5	20	20	17
		17.5	111	107	85
Introduction to Group Work Skills					
	02/06/90	12.0	26	18	13
		12.0	26	18	13
Inv: Interviewing Children in Sexual Abuse Cases					
	12/12/89	2.5	18	18	16
		2.5	18	18	16
Investigations					
	11/07/89	40.0	47	30	18
	04/03/90	40.0	34	25	14
		80.0	81	55	32
Investigations: Cultural Awareness					
	11/14/89	2.5	18	18	16

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
		2.5	18	18	16
Investigations: Developmental Considerations					
	11/14/89	2.5	18	18	16
	04/17/90	2.5	20	20	17
		5.0	38	38	33
Investigations: Effective Use of Confrontation					
	11/02/89	5.0	20	20	16
	04/24/90	5.0	17	17	15
		10.0	37	37	31
Investigations: Family Violence					
	12/05/89	2.5	20	20	17
	05/01/90	2.5	17	17	15
		5.0	37	37	32
Investigations: Interviewing Skills					
	11/28/89	5.0	20	20	16
	04/10/90	5.0	17	17	16
		10.0	37	37	32
Investigations: Medical Indicators					
	05/15/90	5.0	17	17	15
		5.0	17	17	15
Investigations: Neglect					
	12/19/89	2.5	20	20	16
		2.5	20	20	16
Investigations: Substance Abuse					
	12/05/89	2.5	20	20	17
	05/01/90	2.5	17	17	16
		5.0	37	37	33
Investigations: Worker Safety					
	11/07/89	2.5	20	20	16
	04/03/90	2.5	17	17	15
		5.0	37	37	31
Investigations: Medical Indicators of Child Abuse					
	12/19/89	2.5	20	20	16

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
		-----	----	----	----
		2.5	20	20	16
Juvenile Sex Offenders					
	10/17/89	5.0	17	17	16
	05/02/90	5.0	27	27	23
		-----	----	----	----
		10.0	44	44	39
Legal Aspects of Foster Care					
	05/22/90	2.0	12	12	9
		-----	----	----	----
		2.0	12	12	9
Legal Aspects of Foster Care and Adoption					
	11/15/89	3.0	16	16	9
		-----	----	----	----
		3.0	16	16	9
Liability Issues in Social Work Practice					
	02/07/90	2.5	23	23	17
	04/18/90	2.5	10	10	8
	06/27/90	2.5	10	10	10
		-----	----	----	----
		7.5	43	43	35
Licensing Exam Preparation Course					
	04/24/90	28.0	35	20	14
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		28.0	35	20	14
M.A P.P. Training of Trainers					
	03/13/90	40.0	13	13	13
		-----	----	----	----
		40.0	13	13	13
M.A.P.P. Training of Trainers					
	09/27/89	35.0	23	23	20
	10/18/89	35.0	20	20	19
	03/13/90	35.0	20	20	19
		-----	----	----	----
		105.0	63	63	58
Management in Child Welfare					
	09/12/89	35.0	14	14	13
	11/14/89	35.0	21	21	19
	03/13/90	35.0	18	18	14
		-----	----	----	----
		105.0	53	53	46
Managing Diversity in the Workplace					
	05/07/90	5.0	20	20	18

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
		-----	---	---	---
		5.0	20	20	18
Managing Diversity: Dealing with Differences	06/11/90	5.0	9	9	9
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		5.0	9	9	9
Managing Organizational Change	06/04/90	5.0	10	10	10
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		5.0	10	10	10
MAPP - Problem Solving	02/13/90	5.5	60	40	41
	02/14/90	5.5	40	40	39
		-----	---	---	---
		11.0	100	80	80
MAPP Training of Trainers	10/31/89	35.0	20	20	20
	03/07/90	35.0	20	20	18
	03/12/90	35.0	16	16	15
	06/04/90	35.0	20	20	18
		-----	---	---	---
		140.0	76	76	71
Maximizing Benefits for Children	04/05/90	5.0	14	14	18
		-----	---	---	---
		5.0	14	14	18
Mediation Skills	10/05/89	2.0	18	18	18
	12/07/89	6.0	6	6	6
	12/07/89	6.0	5	5	5
	03/21/90	6.0	8	8	5
		-----	---	---	---
		20.0	37	37	34
Normal Child Development	04/26/90	11.0	15	15	13
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		11.0	15	15	13
Parent Success Training	10/30/89	20.0	11	11	10
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		20.0	11	11	10
Pediatric HIV Infection	02/09/90	5.0	15	15	13

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDED
		5.0	15	15	13
Permanency Planning and Mental Illness	05/01/90	8.0	19	19	13
		8.0	19	19	13
Pre-Retirement Seminar	12/20/89	5.0	22	22	22
	01/19/90	5.0	19	19	19
		10.0	41	41	41
Preparing Adolescents for Young Adulthood	08/21/89	11.0	88	88	88
	08/24/89	11.0	94	94	94
	08/28/89	11.0	87	87	87
	12/06/89	5.0	16	16	16
	12/07/89	5.0	18	18	15
	12/11/89	5.0	16	16	11
		48.0	319	319	311
Protecting Children in Substance Abusing Families	10/19/89	5.0	26	26	17
	11/16/89	5.0	47	25	19
	12/14/89	5.0	20	20	20
	01/24/90	5.0	13	13	12
	03/23/90	5.0	52	29	22
	05/17/90	5.0	36	36	22
		30.0	194	149	112
Regional Alcohol and Drug Treatment	09/11/89	18.0	24	24	27
		18.0	24	24	27
Regional Alcohol and Drug Treatment Training	10/16/89	18.0	23	23	19
	02/07/90	18.0	19	19	17
	03/14/90	18.0	24	24	23
	05/04/90	18.0	28	28	17
	05/07/90	18.0	22	22	21
		90.0	116	116	97
Reinforcing Quality Supervision and Management	11/09/89	4.0	35	35	33
	12/04/89	4.0	25	25	25
	02/08/90	4.0	46	46	46

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTEND
		-----	---	---	---
		12.0	106	106	104
Relationship Building b/w Foster Parents and Workers					
	06/12/90	5.0	10	10	8
		-----	---	---	---
		5.0	10	10	8
Reuniting the Incestuous Family					
	01/10/90	5.0	22	22	19
		-----	---	---	---
		5.0	22	22	19
Satanic Cults					
	12/08/89	5.0	23	23	23
	06/12/90	5.0	65	65	45
		-----	---	---	---
		10.0	88	88	68
Search					
	03/12/90	2.5	11	11	9
		-----	---	---	---
		2.5	11	11	9
Service Planning					
	02/13/90	5.0	11	11	5
	03/15/90	5.0	15	15	15
	05/08/90	5.0	9	9	11
		-----	---	---	---
		15.0	35	35	31
Social Work Licensing Exam Preparation Course					
	01/04/90	32.0	48	48	25
		-----	---	---	---
		32.0	48	48	25
Special Education and Psychological Assessments					
	10/16/89	3.5	14	14	12
	04/23/90	3.5	13	13	5
		-----	---	---	---
		7.0	27	27	17
Stages of Case Management					
	11/27/89	10.0	9	9	3
		-----	---	---	---
		10.0	9	9	3
Strategic Planning					
	11/27/89	5.0	26	26	23
		-----	---	---	---
		5.0	26	26	23
Stress Management					

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
	11/16/89	3.0	13	13	4
	11/30/89	5.0	16	16	12
	06/19/90	5.0	6	6	6
		-----	---	---	---
		13.0	35	35	22
Substance Abuse and AIDS Training	01/08/90	5.0	19	19	12
		-----	---	---	---
		5.0	19	19	12
Substance Abuse and Families	10/05/89	5.0	11	11	10
	11/09/89	5.0	15	15	9
		-----	---	---	---
		10.0	26	26	19
Substance Abuse and Fetal Risks	11/06/89	3.0	37	32	27
	04/10/90	3.0	14	14	9
		-----	---	---	---
		6.0	51	46	36
Supervision in Child Welfare	09/25/89	40.0	24	21	15
	11/16/89	40.0	36	25	17
	03/20/90	35.0	22	13	15
	03/29/90	40.0	27	23	15
		-----	---	---	---
		155.0	109	82	62
Supervisors's Curriculum	12/07/89	40.0	21	21	14
	04/23/90	40.0	16	16	14
		-----	---	---	---
		80.0	37	37	28
Talking to Children About Adoption	11/21/89	3.0	14	14	14
		-----	---	---	---
		3.0	14	14	14
Team Building in Times of Change	01/17/90	5.0	9	9	9
		-----	---	---	---
		5.0	9	9	9
The Adolescent Adoptee: A Time of Turmoil	05/01/90	2.5	12	12	12
		-----	---	---	---
		2.5	12	12	12
The Concept of a Family System					

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
	11/09/89	10.0	21	21	13
		-----	---	---	---
		10.0	21	21	13
The Pact Program					
	02/14/90	3.0	18	18	14
	06/14/90	3.0	14	14	12
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		6.0	32	32	26
The Therapist as a Team Member					
	05/21/90	2.0	0	0	6
		-----	---	---	---
		2.0	0	0	6
The Use of Medication in Treatment					
	11/15/89	2.5	19	19	12
	06/20/90	5.0	15	15	13
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		7.5	34	34	25
Time Management					
	11/08/89	5.0	8	8	8
	11/13/89	5.0	12	12	12
	11/20/89	5.0	4	4	4
		-----	---	---	---
		15.0	24	24	24
Treatment Consideration for Children in Foster Care					
	10/16/89	3.0	6	6	3
		-----	---	---	---
		3.0	6	6	3
Understanding 51A's					
	05/07/90	3.0	2	2	13
		-----	---	---	---
		3.0	2	2	13
Understanding Family Violence					
	11/06/89	3.0	25	25	18
		-----	---	---	---
		3.0	25	25	18
Understanding Resistance and Transference					
	10/12/89	10.0	14	14	9
		-----	---	---	---
		10.0	14	14	9
Understanding Substance Abuse					
	01/24/90	3.0	10	10	8
	03/21/90	3.0	1	1	16
	04/11/90	2.0	22	22	22

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDEE
		8.0	33	33	46
Using Mediation with Adolescents and Their Families	02/06/90	5.0	18	18	15
		5.0	18	18	15
Worker Safety	07/10/89	5.0	47	47	15
	11/08/89	10.0	15	15	8
	11/29/89	10.0	28	28	18
	12/08/89	10.0	20	20	20
	12/13/89	10.0	20	20	12
	12/15/89	10.0	23	23	23
	02/14/90	10.0	24	20	12
	02/28/90	10.0	19	19	11
	03/07/90	10.0	23	23	22
	03/28/90	10.0	21	21	12
	04/06/90	10.0	18	18	10
	04/18/90	5.0	42	42	42
	04/18/90	5.0	25	25	22
	04/25/90	10.0	47	35	29
	05/15/90	10.0	36	30	10
	05/23/90	12.0	24	24	24
	06/12/90	5.0	15	15	9
	06/19/90	5.0	10	10	5
		157.0	457	435	304
Working with Black Families	10/10/89	5.0	19	19	15
		5.0	19	19	15
Working with Cambodian Families	10/25/89	5.0	16	16	11
		5.0	16	16	11
Working with Haitian Families	02/13/90	5.0	15	15	13
		5.0	15	15	13
Working with Minority Adolescents	10/23/89	5.0	33	25	18
		5.0	33	25	18
Working with Narcotic/Cocaine Addicted Babies	10/18/89	6.0	42	25	18
	01/10/90	6.0	17	17	11

FY 1990 WORKSHOPS

TITLE	START DATE	HOURS	# APPLICANTS	# REGISTERED	# ATTENDED
	03/14/90	6.0	16	16	11
	05/09/90	6.0	10	10	8
		-----	---	---	---
		24.0	85	68	48
Working with the Hard-To-Reach Client					
	10/06/89	5.0	10	10	8
	04/03/90	5.5	42	27	15
		-----	---	---	---
		10.5	52	37	23
Working with West Indian/Caribbean Families					
	06/06/90	5.0	6	6	5
		-----	---	---	---
		5.0	6	6	5
Working with Your Foster Parents' Therapist					
	03/12/90	2.5	10	10	8
		-----	---	---	---
		2.5	10	10	8

				TOTAL ATTENDANCE:	4414

FFY '91

IV-B PLAN

CHAPTER V

ASSURANCES

ASSURANCES

The Department of Social Services certifies that all prior assurances (as detailed in the FFY'88 Title IV-B Child Welfare Services Plan) remain in effect. Certificate of compliance with the Drug Free Workplace Act of 1988 (P.L.100-690, Title V) was enclosed with the FFY'90 IV-B Plan.

FFY '91

IV-B PLAN

CHAPTER VI

BUDGET

TITLE IV-B/CHILD WELFARE SERVICES GRANT

FFY'91 BUDGET

Direct Service Staff Positions	\$ 1,200,000
Fringe (25%)	<u>300,000</u>
TOTAL DIRECT	\$ 1,500,000
Indirect Costs (6%)	90,000
Purchase of Service	<u>3,025,781</u>
TOTAL	<u>\$ 4,615,781</u>

APPENDIX

GLOSSARY OF SERVICES
LIST OF PREVENTION SERVICES
FFY'91 TRAINING PLAN

GLOSSARY OF SERVICES

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED
BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>ADOPTION AND GUARDIANSHIP</u>	
<u>ADOPTION</u>	
The securing of permanent homes for children under new legal parentage, including the transfer of rights and responsibilities which prevail in the biological parent-child relationship.	Children available for adoption are those children whose families have been documented to be permanently unable, unavailable, or unwilling to parent them. These children are legally free for adoption through the voluntary consent of parents or through court action under Chapter 210 of the Massachusetts General Laws. Also included are children who are likely to be free for adoption at a future date because they are unable to be returned to the care of their families of origin.
<u>ADOPTION SUBSIDY</u>	
Adoption subsidies consist of financial assistance, medical assistance, or both, provided at the time of legalization of the adoption by certain adopting parents to aid in the support of a child with special needs.	Children with special needs who would not otherwise receive appropriate adoptive placement.
<u>GUARDIANSHIP SUBSIDY</u>	
Guardianship Subsidy is the provision of financial assistance to aid in the support of a child with his/her guardian.	Children 12 years or older who cannot return home, cannot be adopted, and have lived with a potential guardian for no less than one year. All three, child, parent and guardian, must consent to the placement.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED
BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>BABYSITTING SERVICES</u> Babysitting is an hourly child care service that provides direct care, protection and supervision to children during some portion of the day or night. Babysitting Services are provided on a short-term basis. Babysitting shall not be authorized on an overnight basis.	Babysitting Services are available to families (including foster families) who need assistance with child care during the parent or primary caretaker's temporary absence from the home. Babysitting Services are part of a spectrum of in-home support services provided to strengthen intact families and to prevent placement. Babysitting Services shall not be provided for any child fourteen (14) years of age or older, unless the child has special needs, assessed and documented by a qualified professional.
<u>COMPREHENSIVE EMERGENCY SERVICES</u> Comprehensive Emergency Services is a coordinated, interagency system for providing immediate and effective response on a 24-hour basis to situations in which individuals, families or children are at risk of immediate danger to their life, health or physical safety.	Comprehensive Emergency Services may be provided to individuals or families when an immediate risk of serious physical or emotional injury exists due to abuse, neglect or other emergency situations (as defined in the contract).
<u>DAY CARE</u> Comprehensive and coordinated developmental child care activities offering direct care, protection and supervision to children outside of their own homes during some portion of the day on a regular basis when parents or guardians are unable to provide direct care. Day care services are available for and designed to meet the needs of the following age groups:	In Massachusetts, eligibility for subsidized sliding fee scale day care services occurs if <u>two</u> conditions can be met. The first, <u>Income Eligibility</u> , requires families' incomes to be under certain specified amounts or from certain sources of public assistance.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populationa
- Infants (from one to 15 months of age) - Toddlers (from 15 to 33 months of age) - Pre-school (from 33 months of age to the age the child is eligible to enter first grade). - School-age (from the age the child enters school to 14 years of age). - Teen parents with their infants, and/or toddlers, are eligible through the age of 21 years. Center-based or group day care for children up to six years of age is provided 52 weeks per year, excluding contracted center closings, in facilities open for a minimum of 50 hours per week. Head start programs may propose a schedule of operation for fewer hours and/or weeks than specified above when the program addresses the needs of high risk families by incorporating an intensive parenting component and a higher staff/child ratio than normally prescribed. The requirement to provide care 52 weeks a year however is negotiable only when programs demonstrate a referral and placement capacity that ensures continuity of care for DSS enrollment families during summer vacations.	The second, <u>Service Need Eligibility</u>, requires that the families' reasons for use of day care services fall into certain categories. <u>INCOME ELIGIBILITY</u> - Families which meet income eligibility conditions are as follows: °Families receiving certain forms of public assistance are eligible because of their source of income. These forms of public assistance are: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income - Disability Allowance (SSI-DA) °Families of children with a documented need for protection from abuse or neglect are eligible regardless of the amount or source of income. °Families whose gross monthly income falls below 115% of the state median income as determined by the Department are also eligible for publicly subsidized day care once they have met the income requirement at the time of intake.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>DAY CARE</u> (cont'd) School-age center-based day care is available 52 weeks per year, excluding contracted center closings, in facilities open for a minimum of fifteen hours per week while school is in session and at a minimum of 50 hours per week during school and summer vacations. Some center-based school-aged facilities may be open a minimum of 44 weeks a year, but must demonstrate a referral and placement capacity to insure continuity of care for enrolled families during summer vacations. Family-based day care is available 52 weeks per year, including contracted provider closings. Hours and schedule of operation must meet the needs of eligible families. Flexible hour day care is available before or after school or evenings 52 weeks per year, excluding contracted provider closings. Hours and schedule of operation must meet the needs of eligible families. Services for Teen Parents and their children are provided for the academic school year, at a minimum, with referral services available to assist with appropriate vacation and summer time placement, when necessary Court Day Care Services are available on a regular basis during court hours.	Intake is limited to families with a gross monthly income at or below 70% of the state median income as determined by the Department except for recipients of AFDC, SSI-DA or families with children in need of protection who are eligible regardless of income. Once a family begins receiving day care services that family remains income eligible until gross monthly income exceeds 115% of the state median income as determined by the Department. Thus the 70% state median income restriction at time of intake does not apply to families who are transferring from one publicly subsidized day care program to another or who enroll a sibling in care. Families are eligible for court Day Care Services regardless of the amount or source of their income. <u>SERVICE NEED ELIGIBILITY</u> - In addition to their eligibility for subsidized day care because of family income level, families must also have a need for the service. Service need eligibility is determined by ascertaining if the family's reasons for use of day care services fall into certain categories: <u>Protective Needs</u> - Services to protect children from situations of neglect, abuse or exploitation and to avoid family separation.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>DAY CARE</u> (cont'd)	-To protect children of families with active protective cases from further abuse and/or neglect (i.e children living at home where 51A reports have been filed within the previous twelve months). <u>Preventive Needs</u> - Services to prevent children from situations of neglect, abuse or exploitation and to avoid family separation. -To prevent abuse and/or neglect, prevent the placement of children in substitute care or aid in reuniting families as children return home. <u>Special Needs</u> - Services to families for achieving or maintaining self-sufficiency, including the reduction or prevention of dependency when the following needs are verified: -To give proper care to a child whose parent(s) or guardian(s) are physically or emotionally incapacitated. -To remedy a physical, emotional or mental disability of the child. <u>Work/Training Needs</u> - Services to families for achieving or maintaining self-support to prevent, reduce or eliminate dependency when the following needs are verified: -To seek or start paid employment or to continue paid employment.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>DAY CARE</u> (cont'd)	-To participate in the Department of Public Welfare Employment and Training Program (ET Choices). -To receive approved training to become more employable: a. Full-time high school or high school equivalency program. b. Full-time education in an accredited college or university not to exceed four years, leading to a bachelor's or associate's degree. c. Full-time vocational training which will give a specific skill necessary to become more employable - not including graduate, medical or law schools. <u>Service Need Eligibility for Services for Teen Parents and Their Children (STPC)</u> - Parenting teen is in school or in an employment and training program. -Parenting teen is starting or continuing paid employment. -Parenting teen is seeking paid employment. -Pregnant or parenting teen is returning to school the following semester. <u>Service Need Eligibility for Court Day Care Services</u> -Parents/guardians/caretakers in court on court related business or accompanying someone to court.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>EMERGENCY SHELTER</u> Emergency shelter is the provision of residential care, on a limited and short-term basis for individuals or families during a period of crisis.	Services for emergency shelter care are provided to the following: °Older children and adolescents, including youth who are or may be adjudicated status offenders (CHINS), or who are on detention status and for whom bail has been set. °Children up to the age of eighteen who are at risk of abuse, neglect or exploitation. °Women in transition (with or without children) who have been threatened with or experienced abuse by someone in their household.
<u>FAMILY SUPPORT SERVICES</u> Family Support Services is a spectrum of preventive and reunification services that support maintenance of the family unit and enables adults and/or children to meet the goals of a service plan. Family Support Services include active home management (e.g., Chore Services) and the purchase of items or services that provide social and developmental opportunities for a family or individual family members. A sub-category of Family Support Services is Parent Aide Services. Parent Aide Services provide support through the development of a mutually agreed upon consistent long term relationship between a trained, supervised individual and a parent or	Family Support Services are available to families receiving ongoing DSS Case Management Services when, in the judgment of the Department, Family Support Services will help strengthen the family unit, decrease or eliminate the need for placement of children in substitute care, and in certain instances, to assist the family during a child's transition home from substitute care.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>FAMILY SUPPORT SERVICES</u> primary caretaker whose family is at risk of or currently is experiencing problems with child abuse or neglect. Parent Aide Services provide support and nurturance help to build self-esteem and promote independent functioning of the parent or primary caretaker; assist in the ability to mobilize personal resources; enhance parenting skills; reduce isolation and enhance parent or primary caretaker's ability to develop appropriate relationships based on mutual respect and to promote effective and appropriate use of community resources.	Parent Aide Services are available to parents, expectant parents or primary caretakers whose families are at risk of or currently experiencing problems with child abuse or neglect. They are part of a spectrum of in-home support services to strengthen intact families and prevent placement.
<u>HOTLINE</u> A system for providing immediate telephone response, including information and referral as necessary on a 24-hour basis, to children family members and disabled adults on issues such as abuse, alcoholism, depression and loneliness, or when it is determined necessary to avoid any serious, imminent risk to the health or the physical safety of the applicant.	Children or family members at risk of serious physical or emotional injury as a result of abuse or neglect. Children or family members who are currently receiving services from the Department.
<u>INFORMATION AND REFERRAL</u> Information and referral is a systematic approach to linking people in need of services to appropriate resources.	Information and referral services are provided to all individuals and families upon request.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>IN HOME SERVICES - HOMEMAKER</u> Homemakers provide support, assistance and training to families in the activities of daily functioning. Homemakers assist families by providing a role model for parents or primary caretakers, helping with child care, teaching budgeting and other home management skills, etc. Services are delivered by trained, supervised individuals who are employed by Homemaker agencies who have purchase agreements with the Department. <u>PARENT AIDE MANAGEMENT</u> Parent aide management assists family members to preserve or restore a family unit which has been or may be impaired. Parent aide management may provide individuals with substitute family living environments on a short or long-term basis, when appropriate. <u>PARTNERSHIP AGENCY SERVICES - CASE MANAGEMENT</u> Case Management is the assumption of responsibility to ensure that the needs of children and their families are met during some or all of the following service delivery functions: investigation, assessment, service planning, service provision, case review and case closure. This may also include the assumption of responsibility for determining the need for, arranging and supervising the placement of children into family resource and specialized family resource settings and ensuring that each child's need for a permanent family is met by performing service planning, service provision, case reviews and case closure functions.	Homemaker Services are available to families who, in the judgment of the Department, need monitoring and teaching assistance to enhance their ability to fulfill family and household management responsibilities. Homemaker services are part of a spectrum of in-home services designed to strengthen families and prevent placement. Parent aide management is available to parents, expectant parents or primary caretakers whose families are at risk of or currently experiencing problems with parenting. Services are provided to strengthen intact families and prevent placement. Case Management services are provided to children and their families requiring such services as determined by DSS staff. Children in placement are children for whom out-of-home, planned temporary substitute care has been determined necessary in accordance with Department policy and regulations, and who can participate successfully in a family setting.

SERVICES TO BE PROVIDED AND TARGET POPULATIONS TO BE SERVED

BY THE DEPARTMENT OF SOCIAL SERVICES, MASSACHUSETTS, FY'1991

Services	Target Populations
<u>PAS - FAMILY RESOURCES</u> Family Resources activities include recruitment, training, and monitoring of appropriate families who are interested in becoming resources for children in need of foster or pre adoptive care. A major emphasis is placed upon matching the make up of a family with the specific needs of a child requiring placement.	Family Resources are made available when birth families are unable or unwilling to care for a child.
<u>PAS - INVESTIGATION & ASSESSMENT</u> Investigation consists of a coordinated set of activities initiated in response to a report of child abuse or neglect. Assessment is the process of working with the consumer to gather sufficient information to determine the consumer's need for service and to establish a service plan.	Investigation is provided to children and families for whom the Department has received a report of abuse or neglect. Assessment is provided to families experiencing stress due to a variety of factors.
<u>POST-LEGALIZATION ADOPTION SERVICES</u> The provision, by a trained individual, of support, intervention and/or treatment through a range of methods on an individual, family or group basis to adopted children and their families after the adoption has been legalized.	Children and adults who have been legally adopted and/or their adoptive families. Members of the adoptee's birth or foster family <u>may</u> be included. The need for counseling must arise from or focus on the adoption.
<u>RECREATION-CAMPING</u> Recreation-Camping is a supportive service which provides an array of activities designed to promote the physical, cultural and social development of children. The Department provides Day and Residential Camping Services.	Day Camping Services are available to children between the ages of 5 and 15. Residential Camping Services are available to children between the ages of 6 and 15. Families must meet both the service need and income criteria established by the Department:

PREVENTIVE SERVICES

The following services may be used to help prevent the need for a child to be removed from the home:

- o Babysitting
- o Recreation
- o Family Support Services
 - Chore
 - Items and Services
- o Day Care
- o Homemaker
- o Parent Aide
- o Therapeutic Services
 - Counseling to WIT
 - Post Adoption Counselling
- o Intensive Family Services
- o Mediation
- o Sexual Abuse Prevention
- o Sexual Abuse Intervention Network (SAIN) Teams
- o Information and Referral
- o Family Planning

This Training Plan reflects the priorities which have been established for the Department of Social Services. It provides a conceptual framework for all in-service and professional development programs which will be presented in the coming year.

Training programs will emphasize the vital role played by direct service staff in the protection of the children in the Commonwealth. It is our belief that the in-service and staff development training goals and objectives, which are outlined in this plan, will provide Department staff with opportunities to increase their knowledge, skills and abilities.

Marie A. Matava
Marie A. Matava
Commissioner

OVERALL DEPARTMENT OBJECTIVES

The Department places primary emphasis upon its basic mission -- the protection of children and the strengthening of families. In so doing, DSS continues to develop programs and methods of service delivery that will increase the capability of the Department to respond to identified needs for both individuals and the community. These needs include:

- The protection of children at risk of neglect and abuse.
- Better preparation for Agency staff through pre-service training.
- The improvement of in-home services to prevent placement, and to increase the use of permanency planning for children.
- High quality services for children who must enter or remain in substitute care through the improvement and increase of trainings for family resource staff, and foster and adoptive parents.
- Increased effective services to adolescents.
- Effective services for children in substance abusing families

In FY'91, the Department of Social Services will direct its training resources to support these missions with the goal of ensuring that staff retain and develop the skills necessary to fulfill their responsibilities. Whenever possible, competent Department staff will be called upon to share their knowledge and skills, and at all times, training will reflect the culturally rich and diverse populations the Agency serves.

A primary objective of training during the coming year will be to train social workers to deal with the rising levels of violence and drug use within families, as this has such devastating effects upon children.

INTRODUCTION

Opportunities for Department staff to increase knowledge and skills are provided through a variety of programs. These include the Social Work Training Institute, the Family Resource Training Institute and the Professional Development Program.

THE SOCIAL WORK TRAINING INSTITUTE

The Social Work Training Institute is the Department's in-service training program. This program offers training in several categories, including:

- Pre-Service Training for New Employees
- Skill-Specific In-Service Training
- Supervision/Management Training
- Clerical Staff Training

1) Pre-service training for new employees

The pre-service training program was evaluated and revised during FY90. The new program puts more emphasis on specific skill development in casework including assessment, service planning, and case review. The model calls for an eight day core curriculum which is done centrally, and a supportive curriculum which is done at the local area office and includes five days of activities such as "shadowing" experienced workers, observing court proceedings, and visiting a foster home. There are two additional days in which new social workers can select courses of their choice from the in-service training program.

The purpose of this fifteen day program is to help social workers to understand the dynamics presented by abusing and neglecting families, as well as appropriate techniques for working with these families. Both DSS staff and expert consultants are used as trainers.

In FY'90, eight Pre-Service programs were conducted which trained approximately 450 new employees. In FY'91, the program will be conducted on a monthly basis, so as to lower the number of participants in each group.

2) In-service: skill specific

These trainings are offered on a statewide basis at the Department's training sites. During FY'91, 91 skill-specific courses are presently planned (see attached list of courses).

Social Work Training Institute
FY 1991

July 5, 1990

TITLE	NUMBER OF TIMES	LENGTH OF WORKSHOP
Adolescent Assessment	1	1 day
Adolescent Suicide	1	1 day
Adolescents and Gangs	4	1 day
Adolescents and Substance Abuse	2	1 day
Adult Children of Alcoholics	1	1 day
Advanced Group Work Skills	1	2 days
Assessing and Treating Neglecting Families	2	2 days
Basic Writing Skills	1	3 days
Battering, Child Abuse, and Substance Abuse	2	1 day
Books and Publications		
Case Recording and Documentation	2	2 days
Confidentiality	2	1 day
Counseling Strategies with Adolescents	1	1 day
Courtroom Testifying	2	1 day
Crack, Cocaine, and Protective Services	4	1 day
Crisis Vs. Functional Turmoil	1	2 days
Cross Cultural Interviewing	1	1 day
Cults, Satanism, Violence, and Child Welfare	2	1 day
Cultural Issues in Supervision	2	1 day
Domestic Violence	4	1 day
Effective Use of Confrontation	3	1 day
English as a 2nd Language	3	3 days
Failure to Thrive	2	1 day
Family Systems	1	2 days
Growth, Development, and Pathology	1	1 day
Interviewing Alleged Offenders	2	1 day
Interviewing Children in Sexual Abuse Cases	3	1 day
Introduction to Group Work	2	2 days
Investigations Training	1	8 days
Juvenile Sexual Offenders	1	1 day
Legal: Foster Care and Adoption Issues	2	1 day
Managing Diversity	1	1 day
Maximizing Benefits for Children	1	1 day
Parent Success Training	1	4 days
Permanency Planning and Mental Illness	1	1 day
Psychiatric Disorders and Medication	1	1 day
Service Planning	2	1 day
Social Worker Liability	2	1 day
Social Worker Safety Training	2	2 days
Understanding Resistance in Casework	1	2 days
Using Mediation with Adolescents and Families	1	1 day
Working with Black Families	2	1 day
Working with Borderline Families	1	2 days
Working with Haitian Families	1	1 day
Working with Hispanic Families	2	1 day
Working with Homeless Families	1	1 day

Social Work Training Institute
FY 1991

July 5, 1990

TITLE	NUMBER OF TIMES	LENGTH OF WORKSHOP
Working with Minority Adolescents	1	1 day
Working with Refugee Families	1	1 day
Working with the Hard to Reach Client	1	1 day
Working with West Indian/Caribbean Families	1	1 day
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TOTALS:	81	148 days

In addition to the in-service trainings a number of special programs will be initiated during FY'91. In celebration of the agency's ten year anniversary, a statewide conference for all agency staff will be held in October. In addition, each of the twenty-six area offices will develop a training symposium for their staff which looks at trends in child welfare during the coming decade.

Another goal of in-service training is to continue to develop trainings on substance abuse, family violence, and social worker safety courses so that staff can be as prepared as possible for this alarmingly emerging trend. The training plan allows for the addition of courses as the year progresses.

3) Supervision and management training

The Department will continue to run the eight day in-service course for area program managers entitled, "Management in Child Welfare". All area Program Managers will have completed the course by the end of this year. In addition, one day of follow-up training will be provided three months after the completion of the program.

The supervisory curriculum, "Supervision in Child Welfare" will be conducted five times this year (with approximately 100 graduates). At the completion of this year over 200 of our supervisory staff will be trained. This program also provides a one day follow-up at the three month point.

Management meetings for Area Directors are run on a monthly basis and Area Program Managers meet on a quarterly basis. A half day is devoted to training at management meetings.

The Department will also offer a variety of programs specifically for supervisors and managers in conjunction with the Department of Personnel Administration.

4) Clerical Staff Training

The majority of clerical staff training is provided through Professional Development so that clerks may take advantage of training which is located close to their offices. The Department will continue to provide pre-service orientation to new clerical staff, as well as a select number of in-service workshops. During FY 91 we will offer skill development courses on the personal computer, and College Information seminars.

FAMILY RESOURCE TRAINING INSTITUTE

In September 1986, the Department initiated the Family Resource Training Institute. The Institute provide a formalized in-service training program to build upon the MAPP Pre-Service Training. In FY'91, 95 In-Service training courses are scheduled to be offered through the Institute. Over 100 MAPP Pre-Service (30 hr) Trainings for prospective foster and adoptive parents will also be conducted through the Institute. In addition, all courses offered through the Social Work Training Institute for the Department's social work staff will be open to foster and adoptive parents. Please see attached list of Family Resource courses.

THE PROFESSIONAL DEVELOPMENT PROGRAM

The Department's Professional Development Program compliments the training available through the Social Work Training Institute. The Professional Development Program differs from the Social Work Training in that it allows management to match the specific educational and training needs of their employees with readily available degree/credit programs. The Department continues to give strong support to employees wishing to increase their professional competence through:

- Formal degree programs at all educational levels
- Partial tuition reimbursement
- Tuition remission
- Workshop/conference reimbursement
- Field placement arrangements for MSW internship

- Tier training programs
- Department of Personnel Administration courses
- University of Massachusetts, CPCS Program
- Salem State Symposium
- Boston University Spring Institute

The Department will continue to work closely with institutions of higher education to expand program and degree offerings which will be of educational benefit for the agency staff. Over 1500 staff participate in Professional Development on a yearly basis, clearly indicating a strong commitment by staff toward skill development.

Family Resource Training Institute
FY 1991

July 5, 1990

TITLE	NUMBER OF TIMES	LENGTH OF WORKSHOP
Adolescent Issues in Adoption	1	1 day
Adolescent Issues in Placement	1	1/2 day
Adolescent Sexuality	3	1/2 day
Adolescent Suicide	2	1/2 day
Adoption Disruption	1	1 day
Adoption Issues for Supervisors	1	2 days
Adoption Placement	1	3 days
Assessment Skills for Family Resource Workers	3	1 day
Behavior Management (English)	3	1/2 day
Behavior Management (Spanish)	4	1/2 day
Bonding Techniques	2	1 day
Building Self-Esteem in Children	3	5 days
Care and Feeding of Support Groups	2	1 day
Cocaine, Crack, and Ice	4	1/2 day
Coping with Loss (Spanish)	2	1 day
Coping with Stress Through Humor	1	1 day
Cultural Considerations in Placement	2	1/2 day
Cultural Issues in Placement	2	1/2 day
Domestic Violence	4	1/2 day
Effect of Foster Care on the Family	2	1 day
Family Resource Pre-Service Training	1	8 days
Family Violence and Sexual Abuse	1	1 day
Foster Parenting the Sexually Abused Child (English)	4	1 day
Foster Parenting the Sexually Abused Child (Spanish)	4	1 day
How to Assess Foster Parents for Adoption	1	3 days
How to Communicate with Your Teen	4	1/2 day
Infertility	2	1 day
Legal Issues in Foster Care and Adoption	2	1/2 day
Managing Aggressive Behavior in Children	1	1 day
Mediation	2	1 day
Narcotic And Cocaine Addicted Babies	4	1 day
Open Adoption	2	1 day
PACT	4	1/2 day
Parent Education Program: Sexuality Education	2	2 days
Post Adoptive Services	1	1 day
Search	3	1 day
Substance Abuse	3	1/2 day
Taking Care While Giving Care	3	1/2 day
Talking to Children About Adoption	2	1 day
The Unattached Child	1	1 day
Treatment Considerations for Children in Foster Care	1	1/2 day
Understanding the 51A Process	2	1/2 day
Working Through Grief	1	1-1/2 days
TOTALS:	95	98.5 days

